

THE MODERN HOSPITAL

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ON HUMANIZING THE HOSPITAL

BY S. S. GOLDWATER, M.D., PRESIDENT, AMERICAN CONFERENCE ON HOSPITAL SERVICE; DIRECTOR, MT. SINAI HOSPITAL, NEW YORK, N. Y.

IN THE July, 1123, issue of the *Ancient Hospital*, one might have read the interesting announcement that St. Bartholomew's Hospital, London, was seeking a "master" who, in conformity with the rules of the hospital, was required to be "gentle, good-tempered, kind, patient to the sick and ailing, and prepared to gratify their needs with affectionate sympathy." This brief extract from the rules of the hospital makes it evident that the motive that prompted Rahere to build St. Bartholomew's was humanitarian, not scientific; the purpose of the hospital was "to give aid to the needy, orphans, the outcasts and poor of the district, as well as to afford relief to every kind of sick person and homeless wanderer." Let us hope that St. Bartholomew's found the kind and gentle master it sought; that the master was able to surround himself with servants as compassionate as himself; and that he experienced no difficulty in obeying his instructions "to withhold from patients all evil rumors" and "in no wise to disturb them when they are resting." Nowadays hospitals are apt to look for efficiency rather than gentleness in their "masters" or superintendents; and recently a strong protest against waking patients at five o'clock in the morning, published in *The London Times*, indicated that some, at least, of our English contemporaries have forgotten the admonition which reads "in no wise to disturb patients

A few centuries ago education centered around a Plato or a Socrates whose magnetic power drew to his feet youth in search of truth. Today giant machine-like institutions known as schools are tending to remove intimate relations between pupil and teacher to the extent that some say that if education in America is to be preserved it must be divested of its "schooling." In some respects hospitals have had a parallel development. From almshouses they have developed into complex institutions often devoid of the fundamental quality of human sympathy. In this article Dr. Goldwater has reached the heart of the problem of getting rid of the "institution" to preserve the hospital.

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According to Booth Tarkington, one of the difficulties of the professional author who seeks to produce a fresh and palpitating human document is "how to get the ink out of it." It might be said that the problem of the hospital administrator who wishes to humanize his hospital is how to get the institution out of it; and in all humility, as one who has tried and never more than partially succeeded,

I confess that the task is a little beyond me. But—never say die! Bertrand Russell, who regards the ways of nature as cruel and abhorrent, and who is baffled and disheartened by the very problem of existence itself, declares that "it is only on the firm foundation of unyielding despair that the habitation of the soul may be safely built." Though we hospital men acknowledge our despair, let us resolve never to yield, and perhaps, notwithstanding our initial failures, we may yet succeed in getting rid of our "institutions" in order the better to preserve our hospitals.

Is it possible that one of the reasons why hospitals are not consistently kind is that human beings do not regard each other as worthy of genuine consideration? One's hopes of a hospital world fit to live in are not raised by a writer like James Branch Cabell, who points out that while children have a temporary lien on tenderness, grown-ups do not usually respect each other. "Why should they," adds this shameless cynic.

If we are wanting in solicitude for our patients, grown-ups and children alike, we shall be repaid as hospitals have been repaid for generations. Confidence is the reward of kindness, distrust, of the lack of it. It would be unkind to name the great municipal hospital which is surrounded by a population among whom there survives the myth of the black bottle, by repute a convenient instrument for disposing deftly of patients who prove too troublesome. With a legend of that sort still firmly lodged in the minds of a people who enjoy the advantages of a Western education, is it surprising that in far-off China, where the steam railroad, mysteriously propelled by an unseen power, and the missionary hospital, prompted by motives unimaginable to the simpler natives, made their astonishing appearance at the same time, the ignorant Chinese peasant, putting the two together, reached the startling conclusion that the motive power of the railroad consisted of human spirits, cunningly extracted from the bodies of Chinese hospital patients on their death-beds? A certain evil repute still clings to missionary hospitals in certain parts of China, despite the shining humanitarianism of the missionaries.

Hospitals and Preventive Medicine

It is a pity that hospitals and doctors are not mentally associated with health rather than with disease. The adage, "an apple a day keeps the doctor away," seems to suggest that the doctor brings the disease, not the cure. A happier association of ideas may result from the growth of preventive medicine, and hospitals will miss their opportunity if they fail to get promptly into this movement. The "big idea" is to get the doctor and the hospital established in the popular mind in association with successful efforts for the preservation of health. Let the doctor be primarily a friend who once a year makes a physical and mental appraisal of his patient; who advises him how to keep health in his body, money in his pocket, and happiness in his soul. In pre-Volstead days one might have legitimately proposed as a substitute for the jingle of the apple, the jingle of beer: "A doctor a year keeps the family in beer."

If we recognize the fact that in the public mind the hospital is a bitter pill in need of a sugar coating, we may hope eventually to win public confidence and approval. W. E. Henley spoke for a myriad of patients when he described his dismal first impression of an English hospital:

"My confidence all gone,
The gray-haired soldier-porter waves me on,
And on I crawl and still my spirits fail—

These corridors and stairs of stone and iron,
Cold, naked, clean—half work-house and half jail."

The hospital social worker ("almoner" in England) is a happy substitute for the soldier-porter, but even the hospital social worker, the patient's friend-designate, is in danger of acquiring a certain rigidity of mind and habit, to avoid which the "hospital hostess" has recently appeared—the latest hope of the hospital humanizer. The hospital hostess who understands her job will never put up with "corridors and stairs of stone and iron, cold, naked, clean"; her first demand is for a pleasant office in which to receive her guests, with a scheme of decoration and furnishing that suggests the home rather than the institution; the hospital which is thus infected, can hardly remain immune against soft feminine influences in any of its departments.

Avoid Depressive Influence

Physical and mental impressions as well as personal contacts may be depressing to a patient, a truth which it is fatal to forget in the planning, arrangement, or equipment of a hospital. Some naturally gentle superintendent must have been sound asleep when an engineer, in a prosperous city in Ireland, was permitted to erect a hospital in which mechanically ventilated wards were arranged side by side like so many crowded packing boxes in a storehouse, thus depriving patients in bed of any view of the wonderful world outside. A result almost as unfortunate was achieved in more recent times by a well-intentioned hospital superintendent who, thinking only of the convenience and efficiency of the nurses (an excellent idea in itself) so arranged the beds of 600 patients that not one could see sky or country. To be compelled to stare for weeks at a blank wall is a severe penalty for permitting oneself to lapse from health. The superintendent of a Scotch hospital who used wood instead of marble to floor his dispensary waiting room because many patients came bare-footed was, to my mind, the abler—he certainly was the more considerate—hospital builder.

A natural incongruity between personal service and large-scale organization is at the bottom of much of our trouble. How can effective, up-to-date medical work be accomplished without organization and system, and how can we arrange for the prompt suspension of a rule whose rigid application threatens to wound ever so slightly the feelings of a patient or of his friend? The ambition of youthful superintendents, eager to demonstrate their executive ability, tends easily in the direction of the drafting of rules; but humane administration calls for

the breaking as well as the making of rules.

But the breaking of rules should be prompted by motives of service, not of servility. A certain superintendent prided himself on his tact, in testimony whereof, he was wont to explain that his subordinates were instructed never to say "No" to anybody without first ascertaining the social quality of the petitioner. While I do not question the honesty of that superintendent, it seems to me that he was trying to build up a successful hospital on a foundation of favoritism rather than fair play. If there is to be any favoritism in a hospital, let it be shown to the friendless patient—else this ceases to be God's own hospital country, and becomes the country of the rich and influential.

Systematic organization tends toward automatism and the machine-like methods of bureaucracy; yet a large hospital cannot wholly dispense with system. It is easy to deal pleasantly and intimately with a single person, but hard to be courteous toward an impatient mob. The hospital information clerk who is calm and collected in the morning, who hears questions patiently and answers them discreetly and quietly, will often be found speaking in a shrill, irritating staccato after experiencing the strain of a multitude of demands. "Of course it is necessary to control the crowd," said a hospital visitor on ward visiting day, as he stepped out of the waiting line; "but I'm different and need no restraint—pray let me pass!" Instantly the crowd broke ranks.

A single patient may be consulted about his preference in the matter of food, but how can the personal preferences of several hundred be respected without multiplying cooks and kitchens, with consequences disastrous to the hospital treasury? But the hospitals are not standing

still; ten years ago, a hospital of 500 beds employed a single dietitian who, assisted by one pupil nurse, supplied all of the special diets the ward patients received; ten dietitians are employed in the preparation of special diets in that hospital to-day, and their increase denotes humanitarian as well as scientific progress.

Many difficulties vanish when individual physicians and nurses are kind and considerate. A distinguished visiting physician made the bril-

liant suggestion that on ward rounds a physician should sit down for at least a minute beside the bed of each patient. What assurance has a ward patient that he has really been noticed by the physician who marches by, head in air? How successfully would a physician be who in private practice breezed into a sick room, put a perfunctory question or two while standing, and then walked out again? How much confidence would the patients of that physician have in him? Heaven may forgive the physician who first frightens the life out of his patient, and then comes back with a faint note of intended encouragement; from us, that physician will receive no mercy. And the lay public is surely finding him out, for only recently "F. P. A." ridiculed mercilessly the physician who says, "You are in a frightful condition, but I can make you well!"

Various expedients have been suggested to counteract the dehumanizing influence of mass treatment in large hospitals, which so profoundly affected Arnold Bennett that he puts into the mouth of one of his characters in "Riceyman Steps" the shocking statement that he would die rather than enter an institution where individuality is so outraged by inelastic rules and lack of privacy. It has been wisely suggested that hospitals should not be permitted to grow too large;

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but will it help the sick if hospitals are kept so small that adequate technical treatment becomes economically impossible, and the development of the highest technical skill improbable. One well-equipped, well-managed general hospital, not too large, is better for a community of 100,000 people than three or four pitiful makeshifts. It was Mark Twain who advised, "Put all your eggs in one basket and watch that basket."

"Abandon large wards; give every patient a separate room," is a suggestion that comes trippingly from the tongue of those who do not understand that to put a patient in a single room and leave him to his own devices, may be alien to true kindness. "I like our new single room wards," said a hospital nurse, "that is to say, I would like them if only I had some means of knowing what is happening to my patients!" Privacy with adequate attention is one thing, separation with neglect is another. Besides, the sick are often terrified by loneliness; it is as true as ever it was, that misery loves company.

Among many wonderful doctors and nurses are some who have the defects of their professional qualities. Concentration on technical problems is not only not a criminal offense, it is indispensable to scientific progress. Fearing that too much attention might be paid to scientific problems, a kind-hearted person caused to be written over the threshold of a German hospital the motto, "Forget the disease and remember the patient." This is an excellent motto for the hospital, a dangerous one for the doctor, to live by. It is the business of a doctor to keep his mind on disease, to observe symptoms closely—he cannot otherwise successfully fight his patient's battle; hence, a more satisfactory motto for the hospital physician would be, "Study the disease, but do not forget the patient." Nevertheless, it is as true to-day as it was in 1636, when St. Vincent de Paul thought it necessary to organize his lay visitors to the hospital wards of Paris, that certain needs of hospital patients fail to receive the attention of the professional staff; hence—the hospital social worker.

Is Any Patient Undesirable?

In the lexicon of humanitarianism, there is no such term as "undesirable patient." The hospital which studiously informed the public that "no patient was ever turned away," but which slyly concealed the fact that every year a thousand "undesirables" were dumped on a nearby municipal hospital within a few hours after admission, may have deceived its public; it did not, in the quaint Oriental sense, "acquire merit." Father Damien regarded no case of leprosy as undesirable; nor should we. A patient may be appropri-

ate or inappropriate to a given hospital service; in either case the hospital has an obligation—in the first case to care for the patient, in the second to obtain care for him; and in every case the true nature of the service rendered should be candidly told.

Service Is Improving

In a hundred ways modern hospitals are improving in personal attention and service. Crile has shown that the danger of surgical shock can be lessened by controlling the conditions under which anesthetics are administered. The surgeon's viewpoint and that of the patient cannot be the same, but the closer the understanding between surgeon and patient, the better;

"His mind at ease, the surgeon plies the knife;
I think of home, my children, and my wife."

The semi-starvation of the dispensary patient who is forced to stand or sit in line for hours before being examined and treated, is a serious fault which may be ameliorated by providing a dispensary lunch counter. The heavily laden garbage pail in the average ward kitchen tells a story in part of meals not properly planned, but still more, of patients too weak or dejected to help themselves to the food that is put before them. I suspect that in certain hospitals in Japan, where the hospital administration provides no food for the patients but where relatives are permitted to bring raw food from home and to prepare it in the hospital kitchen, patients who do not require scientific regulation of their diets are at least as well fed as are many of the patients in our American wards.

The body of the acutely sick patient may be starved in consequence of inattention; so may be the mind of the convalescent. The convalescent mind is best provided for in hospitals where libraries are kept in circulation by social workers or volunteers. No librarian has a more delicate task than the hospital librarian who undertakes to provide the sick with suitable literature. Here is an art that requires further development under the expert guidance of competent psychologists. "In a long sickness," said a recent writer, "one does not want to be cheered, one wants to be transported. For a lot of pain there is nothing like a detective story; but when your temperature goes above 101° it is just as well to skip the murders."

One is often tempted to suggest the abrogation of all rules that restrict visits to the sick. I found a certain fascination in the wards of Japanese hospitals where, at night, friends of both sexes were permitted to bring mats and sleep on the floor. I am not sure, however, that such a practice is suited to America. In our country, the

presence of visitors in a ward may interfere with proper examination or treatment, but the visitor who for this reason is denied access to the ward is entitled to an apologetic explanation. When the enforcement of any rule leads to many protests, it is well not to abandon it precipitately, but to reconsider it impartially.

The strict exclusion of parents from the children's ward of a certain hospital has sometimes been denounced as "cruel and unusual punishment." The rule was adopted, of course, in the belief that the introduction of contagious disease might thus to some extent be controlled. As a matter of experiment, the hospital once suspended this rule; but the rule was restored when it was found that after each visiting hour the average temperature of the children was up about one degree; besides which, the children were inconsolable for hours.

Occupation for Convalescents

The convalescent patient, whether big or little, needs occupation. The yearnings of convalescent children for occupation and companionship may be supplied in part by a kindly kindergartner. Games for small children take the place of a circulating library for grown folks. The latter do not much fancy being left to their own thoughts. As H. M. Tomlinson recently put it, "People dread being left alone with their thoughts for the reason that they cannot face them—perhaps because they soon grow weary of staring at nothing." It is particularly hard for one who is sick to be compelled "to stare at dark doubts he would rather ignore."

The hospital patient is subject to many small deprivations at a time when to be deprived of health would seem to be hardship enough. It was native sympathy which allowed the sick worker in English hospitals his accustomed daily beer. "No smoking" is the rule of safety in hospitals, and there is justification for its strict enforcement, especially in non-fireproof hospital buildings; but in military hospitals, during the war, there was nothing that the men seemed to enjoy so much as their tobacco.

The modern hospital is conscious of its obligations and eager to finish its job. It is a healthy sign that physicians and surgeons everywhere are demanding the establishment of follow-up systems. Hospitals which invite discharged patients to comment on their hospital experience, learn much that is of advantage and that might not otherwise be known. The patient who has been discharged from the hospital derives a good deal of satisfaction, and eventually, in many instances, actual physical benefit, from the cordial personal

letter which informs him of the hospital's continued interest in his welfare.

The Patient First

We have, I fear, all heard patients beg for water when no nurse was by to give it to them. And there are other forms of attention which patients in bed urgently require and which they cannot always get as promptly as might be desired. The intern who puts his request for the personal assistance of a nurse above the exigent claim of a suffering patient forces one to the reluctant conclusion that he is an incredible, unmitigated cad; and one is strongly tempted to speak in similar terms of the alleged nurse who, forgetting the noble traditions of the profession with which she claims fellowship, seems by her manner to say to her helpless and troublesome patient (she does not often say it in so many words), "you have made your bed; now lie in it!"

How some patients would love to have the privilege of wearing their own clothes in the ward! Perhaps they would be less insistent if the practical and sanitary aspects of the case were clearly and patiently explained to them. It required twenty-seven years of effort to persuade the Chinese to give up their own clothes in a missionary hospital in Manchuria, but the patients were much better cared for when finally they accepted the cleaner and more appropriate garments which the hospital provided for them.

The visits of spiritual advisers afford genuine solace to hospital patients who are not yet *in extremis*, yet patients who are not dangerously sick may hesitate, unless specifically encouraged, to ask for such visits. A little girl in a Jewish hospital gave a humorous turn to the matter when on being asked whether she knew who the dignified gentleman was that had just passed through the ward, exclaimed: "Oh! yes, he is the rabbi." "And what does the rabbi come here for?" "To prey on us," was her reply.

No effort should be spared to get word to the friends of a patient when it is seen that the fight for his life is hopeless. It is not enough to notify the relatives of such a patient that they may visit the hospital at will and remain as long as they like; their comfort must be looked after while they are there. I know of one hospital that has made many friends for itself by declining to accept fees for furnishing food or shelter to the friends of dangerously sick patients.

While it is the right of a patient in a "closed" hospital to see his family physician as often as he may desire, a right which is equally his but upon which he is not likely to be so insistent is the precious right of protection from all quacks

and quackery. Happily, a recent court decision established clearly the right of a public hospital to exclude from practice in its wards persons deficient in medical training and skill; but for this, hospitals might have been forced to become accessories to malpractice.

The principle is well established in law that no hospital patient may be permitted to suffer from neglect; I have never been able to square this reasonable rule of law with the acknowledgment of hospitals that they are short of nurses, for a shortage of nurses is *prima facie* evidence of the neglect of patients, which is inadmissible on any plea. The number of special nurses that a hospital employs to help individual patients through critical illnesses is a fair measure of its sensitiveness to the appeals of humanity. How many hospitals, one wonders, have a satisfactory record of such employment?

The Patient's Right to Protection

The sick have a right to be protected from nuisances which tend to arise in hospitals. Patients occasionally become delirious, and may alarm their neighbors. For such patients, as well as for those whose sands are running low, and whose last hours should be consoled by the presence of those near and dear to them, separation rooms should always be at hand. By the use of screens, the temporary privacy which is the right of every human being in a civilized society, may be provided even for patients in large wards. It is cruel to ask a convalescent patient to partake of food in a ward containing persons who are seriously sick; hence every ward should have its day room or dining room. Examining and treatment rooms are needed, to which those may be taken who require prolonged, painful, or depressing examination or treatment.

In the location, designing, and construction of the hospital the production and dissemination of all manner of noises should be considered and combated. The silent elbow of the practised cleaning woman is preferable in a hospital to a noisy vacuum cleaning system. Signal and telephone systems should be installed in such a manner as to disturb patients as little as possible. Elevators, kitchens, and sink rooms should be placed at a distance from sick rooms and wards.

The Note of Cheer

There should be a note of cheer not only about the reception rooms of the hospital, but about the wards, and indeed about all parts of the hospital. Color may be used in many ways to enliven hospital interiors, even though stained glass windows as beautiful as those of Chartres cathedral are be-

yond reach. For children's wards and day rooms, stories told in pictures are appropriate:

"Dear, old, delightful legendary themes

Pictured in colors bright as children's dreams."

It is a far cry from the acceptance of the jail-like hospital of Henley's verse to the systematic employment of interior decorators by modern hospitals; but I think that that architect went too far who, in endeavoring to lend a cheerful aspect to a nurses' home located in a rather dingy quarter of a certain city, enclosed the electric bulb over the front door in a bright red globe, thus causing misunderstanding among the neighbors, inviting hasty inquiries from the police, and spreading consternation among the nurses.

The susceptibilities even of medical visitors were considered by a hospital architect who provided for a certain operating room a floor of dark red tile in the center, lighter red beyond, pink beyond that, with a white border, and who explained that in this manner he hoped to conceal as much as possible the presence of blood on the floor. Of greater importance from the standpoint of the patient is the use of floor material which is not too cold or, where the use of cold material is regarded as necessary for sanitary reasons, the provision of slippers for the use of patients who are able to get out of bed.

The Money Question

Gratitude awaits the genius who will show hospitals how to keep the question of money in the background. It has been the sad experience of hospitals which do not, figuratively speaking, hold a pistol at the heads of patients on admission, that a part of their legitimate income is forfeited. From a humane standpoint I like the financial traditions of the British voluntary system; for generations the British voluntary hospitals prided themselves upon the fact that no money was demanded or accepted from any patient. Of late, however, even the British voluntary hospitals are shifting their ground, for two reasons; first, they need the money, and second, they are coming to recognize the fact that the prosperous as well as the poor are entitled to hospital care. The liberal practice of American hospitals, providing for payment on a sliding scale according to means, is, it seems to me, entirely consistent with sound social policy and with kindly consideration for all individuals and classes.

Most patients who are able to pay their way are glad to do so, but no one likes to be forced to pay. A polite request for payment is better than an uncompromising demand. "Politeness is a dangerous thing for the ordinary man to fool with," said a writer; for "if you aren't careful

how you use it, somebody is certainly going to think you are trying to get money out of him." In dealing with private patients, hospitals must unfortunately run this risk. There is a fine acceptance of mutual responsibility in a certain hospital in the South where no payment is exacted either on admission or during treatment, but where on leaving patients are permitted to deposit what they please in a contribution box which is placed conveniently near the exit. A large out-patient department in Canada prospers under a like arrangement.

By definition the professional man is supposed to use his skill for the benefit of others and not for personal ends, and one can picture physicians, under a happier social system, practising their profession without a thought of pecuniary reward. Obviously, the physician who works solely for pay degrades his profession. In England physicians are beginning to demand payment for professional services to ward patients, especially in instances in which the hospital derives income from sickness insurance funds. It is a pity that the physician must think about money matters at all for, like the artist, he is at his best when he is single-minded. An acute critic, Sarah N. Cleghorn, recently said: "It may be dangerous to the single-mindedness of artists to associate earning capacity with the passion for self-expression. Would it not be dangerous to children's play to pay for it, or to pay lovers for courting?"

In hospitals, the question of spending money, like that of collecting it, has humane aspects. Blood transfusions come high, but often it is a case of transfusion or a speedy end to life. The imperative needs of patients should be met regardless of expense; moreover, those who work in hospitals and who have no other means of livelihood should receive proper payment for their services.

In a letter addressed to a "modernist" bishop of the third century, Origen, the outstanding Biblical scholar of his time, quotes the law: "Thou shalt not remove the ancient landmarks which those before thee have set." Yet we today know that the possibility of progress hinges on the removal of landmarks, and that the landmarks that chiefly obstruct human advance are erroneous ideas, firmly rooted in common thought. It is my belief that many of the minor abuses that exist in public hospitals are due to our inheritance of the "charity hospital" tradition—to the notion that between patients in the public or free wards of a hospital and paupers, there is no real distinction, and to the tacit assumption that paupers are a bad lot generally—useless to themselves, a burden to society, mentally deficient,

probably vicious, and without any saving grace. If paupers are like that, and if free patients are paupers, why bother? Well, a great many hospital workers are bothering, for in their eyes the hospital patient is not a worthless derelict, but a brother in distress. There is a world of encouragement in the steadily rising standards of hospital service; but most encouraging of all are certain little things that show consideration for the feeling of patients. The hospital that, in order to avoid stigmatizing patients as "tuberculous," and to strengthen the confidence of patients in itself and in themselves, thoughtfully changes the name of its tuberculosis clinic to "department for diseases of the chest," has removed an old landmark, has parted company for all time with the condescending spirit of the charity hospital, offspring of the impersonal and cold-blooded almshouse of old, and has become a humane institution, which eventually will find the way to the glorious accomplishment of its noble aims. And its glory will not be to itself alone, for in the words of George Herbert:

"A little glory mixed with humbleness
Will cure both fever and lethargickness."

FIRST ADDITION TO NATIONAL LEPER HOME COMPLETED

The first of the additional buildings provided by congressional act of February 20, 1923, to enlarge the National Leper Home at Carville, Louisiana, have been completed and twelve lepers who had been temporarily detained elsewhere were moved to Carville, April 4.

The additional buildings, all of which are under construction, will be rapidly made available for patients, and it is believed that they will be fully occupied within a few months. The appropriation, amounting to \$650,000, provides additional beds for approximately 240 patients and increases the present capacity of the institution to more than 400. The home will, however, still lack a hospital building proper for the care of the blind, crippled, tuberculous, mental and other classes of patients requiring nursing and highly specialized care. The need for a therapy building where instruction may be given in arts and crafts and other diversional employment is also felt by the patients of both sexes, who necessarily require some employment or amusement in this place where they are confined for life or until they recover.

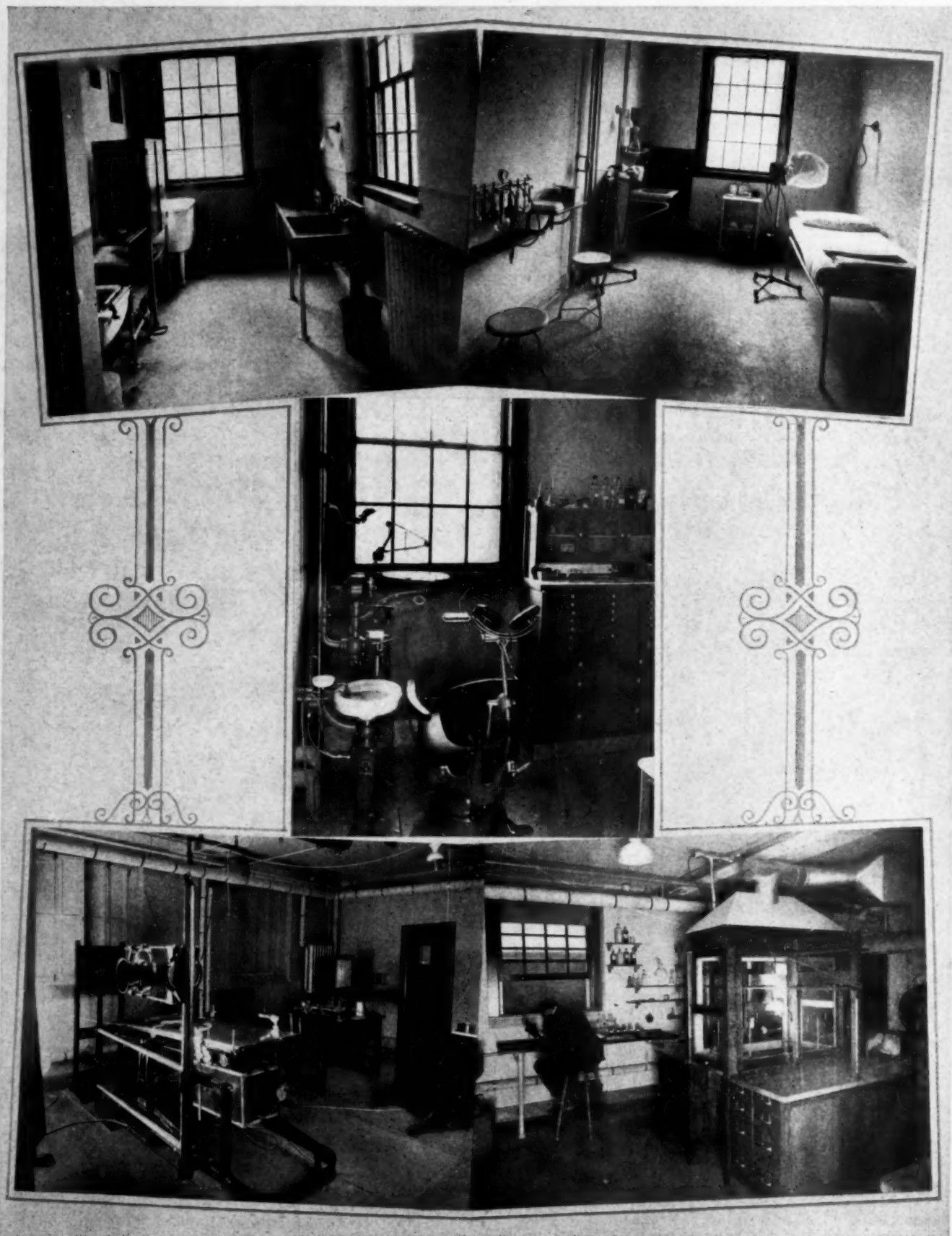
JOHN E. RANSOM WITH A. H. A.

The American Hospital Association has secured the assistance of Mr. John E. Ransom, director, Michael Reese Dispensary, Chicago, Ill., who will give part-time to the work of the organization.

CORRECTION

The picture which appears on the cover page of the May issue is the Baylor Hospital, Dallas, Texas, and not the Stuart Circle Hospital, Richmond, Virginia, as indicated in the table of contents.

INTERIOR VIEWS OF THE ESSEX SANATORIUM, MIDDLETON, MASS.



(Upper left) one of the eight utility rooms of the Essex Sanatorium; (upper right) one of the four examination and treatment rooms; (center) dental room and equipment; (lower left) x-ray room showing apparatus; (lower right) corner of the laboratory.

THE ESSEX COUNTY TUBERCULOSIS SANATORIUM, MIDDLETON, MASS.

By JOHN H. BICKFORD COMPANY, ARCHITECTS AND ENGINEERS, BOSTON, MASS.

ON A wooded hillside of Middleton, Mass., some distance from the public highway, stretches the long and finely proportioned group of buildings comprising the Essex County Tuberculosis Hospital, better known as Essex Sanatorium. With a background of trees which afford protection from the prevailing northwest and northeast winds, and accentuate its lofty position overlooking a wide expanse of open country, the hospital immediately impresses the visitor with its beauty and air of completeness. Good taste in architecture and a high degree of engineering skill have combined to make it the newest of its type and one of the most complete of sanatoriums.

The Essex Sanatorium is about twenty-five miles north of Boston and is easily accessible to the surrounding country which it serves by trolley, steam, and macadam roads. The buildings consist of a central pavilion flanked upon either side by a symmetrical wing, joined to the pavilion by a one-story glazed arcade. The pavilion has three stories and a low basement.

The buildings face about ten degrees west of south. The front exterior walls are treated with gray stucco of moderate roughness of texture, relieved by a trim of ivory-tinted artificial stone. The exterior rear walls are veneered with a very light shade of vitrified brick. The backing of all exterior walls is interlocking hollow tile.

Administration Building

As the visitor enters the administration building through the main doorway under a semi-circular portico he finds himself in a broad hall, a

reception room for visitors and patients. Here are the general office with superintendent's private office adjoining, and the medical library on the left of the reception hall. On the right are the staff dining room and the medical offices consisting of the superintendent of nurses' office, examination room and throat room, all of which are well equipped for making general and special examinations.

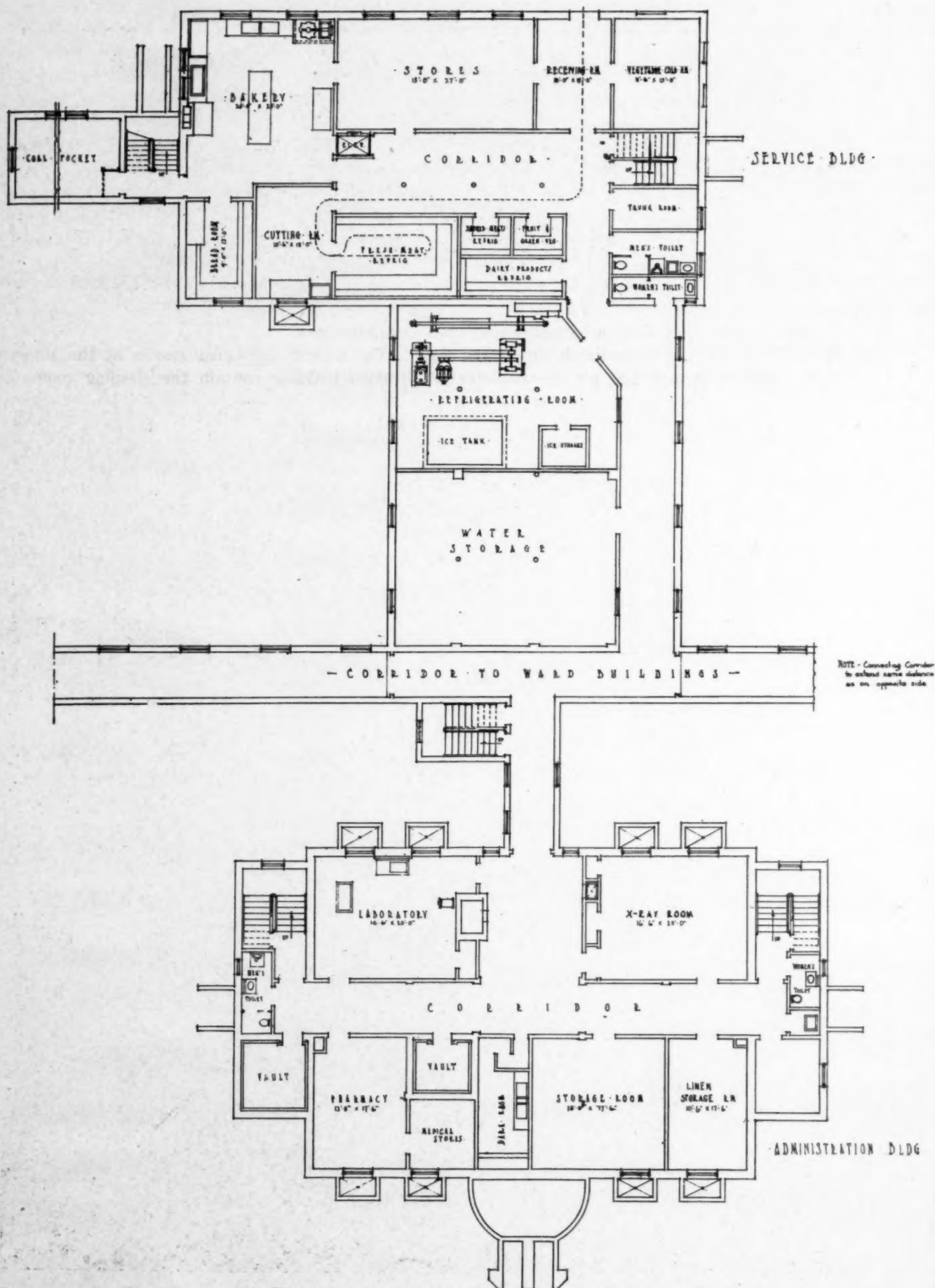
The second and third stories of the administration building contain the sleeping rooms for certain members of the staff, complete with sitting room and baths, while in the basement are located an x-ray room and a pharmacy, both adequately equipped, and a laboratory supplied with the most modern apparatus and devices for both pathological and research work. Here also are several small offices, and the general linen room for the whole institution, besides fireproof record vaults, lavatory and toilet rooms for both men and women and a large general storeroom.

Passing from the reception hall in the first story of this building, one may continue through the glazed corridor to the patients' dining hall, a room spacious in size, architecturally attractive and full of light and cheerfulness, the room being supplied with light and air by four very large windows on each of two sides and having semi-circular transoms that may be opened inwardly. These windows open toward the east and west, affording sunshine both forenoon and afternoon.

Immediately in the rear of this dining hall is the service building, the first floor of which contains the nurses' dining room, servants' dining room, the serving room for the main dining hall,



General view, Essex County Tuberculosis Sanatorium, Middleton, Mass.



Basement plan, administration group.



Administration building.

the main kitchen and the steward's room.

The serving room is placed so as to give rapid and convenient service to all three dining rooms and is equipped with steam tables, hot closets, a specially designed milk cabinet cooled from the refrigerating system, cup warmer, bread and pastry cabinet, coffee urns and the customary small utensils for quick and economical service. Adjoining the serving room is the main kitchen, to one side of which, opening into the serving room, is the dish-washing room. The kitchen, including the dish-washing room, is a model of compactness and convenience, and is fully equipped with modern devices and machines to save labor and to facilitate rapid and skillful work.

Arrangement of Kitchen

Especially interesting is the arrangement of the large French range and the steam cooking fixtures, all of which are grouped in the middle of the room with ample space all around, while an eight-door refrigerator is close to the chef's cooking table.

The dish-washing room was especially designed for cleansing and sterilizing the dishes used by the patients, which are kept entirely separate from those used by the staff, nurses and servants. If run to its full capacity, the machine in this room will wash, sterilize and dry 2,000 pieces an hour, all with the help of two persons. In the basement of this building is located the bakery, the equipment of which in point of convenience and completeness rivals that of the kitchen above. Here also is the cold storage plant, divided into five separate compartments to avoid a transfer of natural odors. Its capacity is such that, when filled, it defies the effects of possible strikes and embargoes on transportation lines. One of the most unique and important adjuncts to the cold

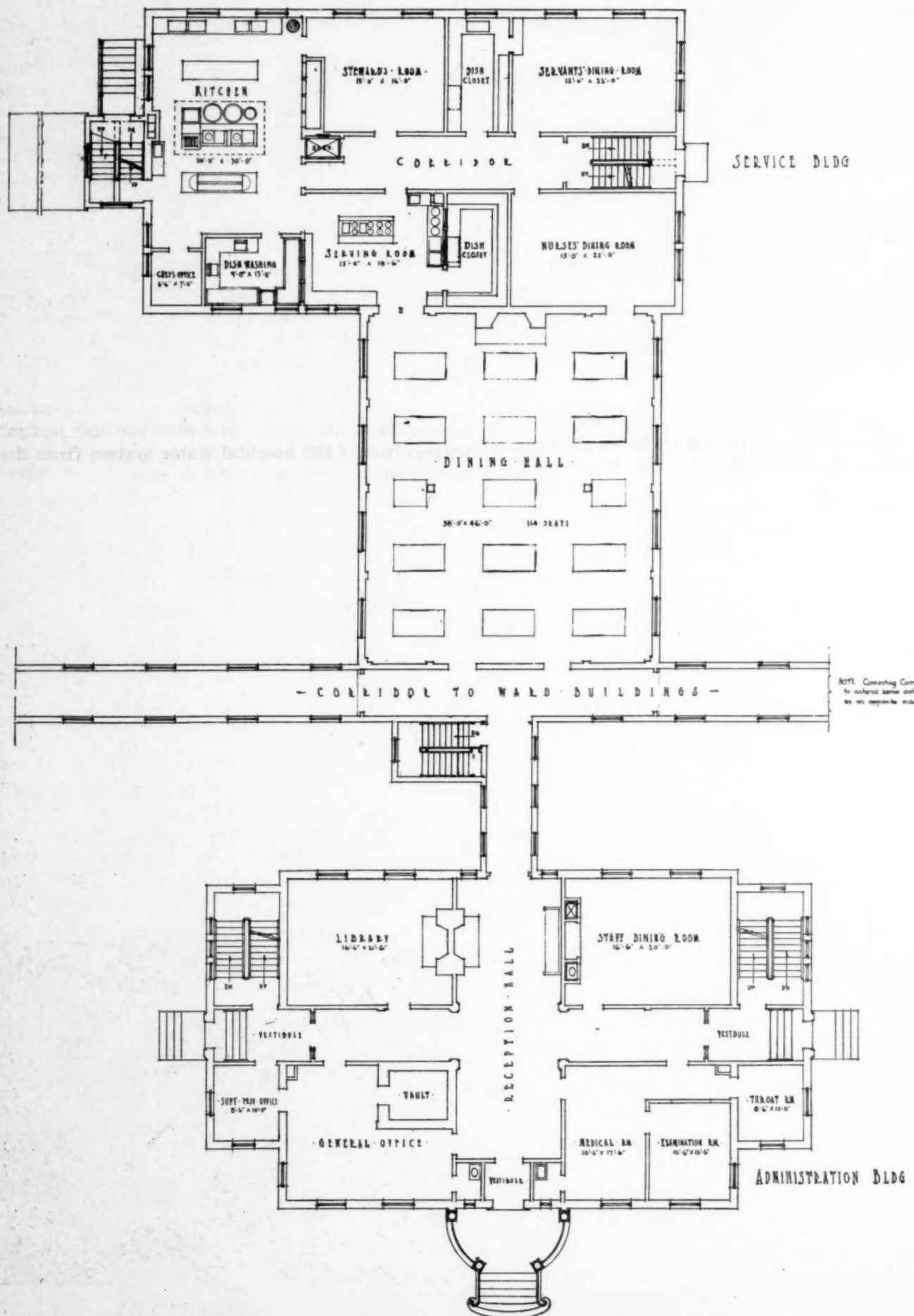
storage plant is the garbage cooler, so arranged and connected to the ammonia circulating system that all garbage from the hospital buildings is kept at a temperature that will not breed or attract flies, nor permit fermentation prior to its being taken away. Other adjuncts are the ice making tank and storage space for ice. Near this section of the basement are two storage tanks of 5,000-gallon capacity for water. These tanks are supplied with necessary additional pressure to supplement that of the public water service. Town water pressure at this basement level is indicated at thirty-one pounds per square inch, which is too low for good service upon the upper floors of the hospital buildings. This pressure is augmented in the storage tanks by means of electrically driven pumps, automatically controlled, to give a suitable working pressure. An ingenious arrangement of valves provides for the instant segregation of the hospital water system from the town supply, always with a reserve of 5,000 gallons. All drinking water, and that used for cooking purposes, both hot and cold, is thoroughly filtered.

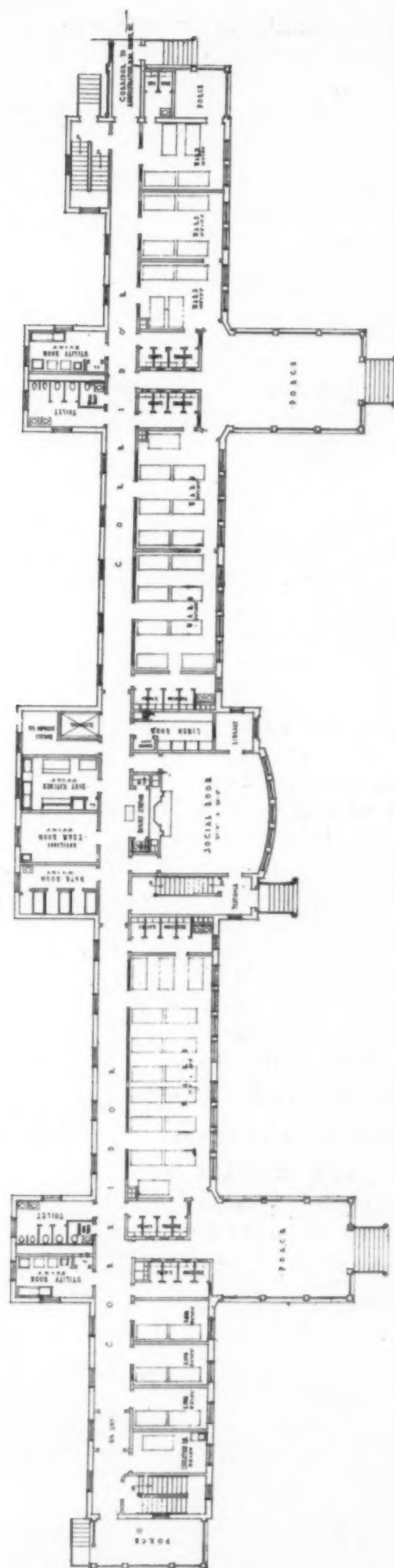
Each Wing a Hospital in Itself

The two long two-story wings which extend to the right and left of the central pavilion, or administration group just described, with which they are connected by glazed arcades, contain the quarters occupied by the patients themselves. The outstanding feature of these wings is that each of the four floors (two in each wing), is a hospital in itself, the facilities and equipment being so arranged that the nurses, orderlies and assistants perform their duties in groups, a separate group for each floor, all groups working separately under the general superintendent and superintendent of nurses in the administration building. In other words, each of these four



Superintendent's house.





Above—plan of central plant and laundry: (left) basement plan, (center) first floor plan, (right) second floor plan. Below—first floor plan of the two-story ward buildings

floors is organized and administered as a separate unit, each of which is devoted to the treatment of tuberculosis in some one of its various stages. It would be difficult to produce anything more complete than the arrangement of these subsidiary hospitals, for each is planned with the idea of making it as comfortable as may be for the patients, and also with a view to making possible the most effectual work on the part of nurses and attendants. Through each of these minor hospitals there extends on the north side a wide service corridor from which one may enter the wards and the various rooms and departments which pertain to their operation.

Each of the minor hospitals has three so-called "terminal rooms," and each has its own isolation room, cut off by air locks, for contagious diseases. These rooms are so arranged that they may be entirely isolated from the rest of the hospital, and each has its screened sleeping porch and communication by stairway with the out-of-doors. Instead of having one general wash room and dressing room for patients in each of these separate hospitals, each of the larger wards has its separate wash room opening directly from it. Part of each wash room is divided into tiny dressing rooms each of which is shared by two patients, each patient having his individual locker in which his small belongings are kept.

Adequate Provision for Fresh Air

In hospitals for the treatment of tuberculosis, arrangements are made for keeping the patients in the open air as much of the time as is possible. In this instance the wards are intended to be open to the air, in all but the most extreme winter weather, by means of casement windows. In order that the air within the wards may be kept in constant circulation in cold weather, heating radiators are placed along the walls which divide the corridors from the wards, and on opposite side from the windows, in order that the warm air, rising from near the floor, may assist in keeping the air at the patients' heads in constant motion.

The lateral porches with which this hospital is provided, are a very successful solution of a prob-

lem which heretofore has meant the darkening of the wards and exclusion of the sun; here they are placed so that their smaller dimensions join the building at right angles and at points which are not occupied by wards, so that neither light nor air is kept from the patients and the porches themselves have three sides open to the air and sunshine, and are screened against insects. In winter these porches are much more successful than anticipated.

Special Operative Conveniences

A few conveniences that promote efficiency in operating are the service corridors in the basement where all noisy trucking of food, linen and ward supplies is done and from there taken in automatic electric elevators directly to the centralized grouping of linen and general supply rooms and diet kitchen for each hospital floor unit.

The food is conveyed from the main kitchen to diet kitchen in heated food trucks, the containers of which are interchangeable with the steam tables throughout the entire plant.

The wide corridors and elevators permit the moving of all patient beds equipped with the five-inch rubber-tired castors to any

part of the institution; such as x-ray, ultra-violet ray, operating and treatment rooms.

A signal system which operates a red light, a gong and a buzzer is provided for each bed. There is also the "tell-tale" light over the superintendent of nurses' or night matron's desk in administration building which shows when calls on the different floors are not answered promptly.

In addition, each room and ward are provided with an additional green light signal which is used to call for additional help.

There are two utility rooms in each unit provided with sterilizer, slop hopper, pan warmer and blanket tub all conveniently arranged. A 24-inch space is provided between the walls of utility and toilet rooms to make all plumbing pipes accessible.

The largest ward is of ten-bed capacity which, with the many smaller wards, afford the segregation of patients into small groups according to their physical condition and personal likes and



Main dining room for ambulatory patients.

dislikes. All locker rooms, baths, toilets, recreation and reading rooms for patients are artificially ventilated, thereby furnishing an abundance of fresh air at these places when windows cannot safely be opened.

In addition, each floor and unit is equipped with automatic telephones, fire alarm boxes conveniently arranged, and special drying closets for bedding. While the arrangement of wards and rooms on only one side of the service corridors for advantages of sunlight, compels quite a long walk from the central nurses' station on each floor to some of the rooms, this walk is on one floor and the two utility rooms are located so conveniently as to facilitate the care of the bed patients who are naturally located there.

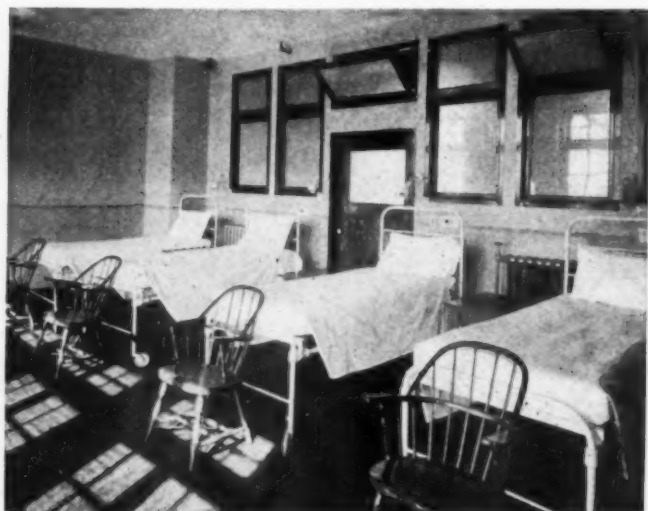
Special Sanitary Features

Some of the special sanitary features are the lavatory bowls which are equipped with spray faucets operated by the wrists so that all patients and employees must wash in running water; the bowls being merely catch basins.

All sinks throughout the entire plant are four inches away from the wall to facilitate cleaning and to prevent breeding places for vermin. The water faucets of sinks are fitted with special sleeves which eliminate sharp angles that are hard to keep clean on the ordinary faucet.

The marble slabs and bath tubs are built flush with the walls.

The floors of the service corridors back of the wards are covered with linoleum laid with terrazzo borders and bases which eliminate noise and facilitate cleanliness. All sharp angles on doors, windows and baseboards tending to retain dust are eliminated where possible. These sanitary features plus an abundance of sunlight to all rooms where patients are quartered, safe-



Typical four-bed ward. Note the sunshine indicated by the shadows on the floor.



Interior of one of the four lateral porches.

guard the employees of the sanatorium from contagion.

In planning this sanatorium three other important adjuncts have been provided. In the basement of the east ward building is an assembly room supplied with complete moving picture apparatus. This room will seat nearly 100 persons and is unusually bright and attractive for a basement room. In the west ward building, in a corresponding position to that of the assembly room, is a chapel with a seating capacity of seventy-five persons. Both of these rooms are artificially ventilated and each is supplied with a small emergency room and toilet facilities for men and women.

Mortuary Room Well Equipped

A mortuary room has been provided in the rear of the basement of the west ward building at a point where the transfer and attention to a deceased patient is attended with the greatest privacy. This room is complete in every detail, including an autopsy table, a four-section cooler and surgeon's toilet facilities. This room is also artificially ventilated and heated by indirect steam.

To make the institution still more complete, each of the four hospital floors, already described, has an auxiliary examination and treatment room, one of which is thoroughly equipped as an operating room and two as ultra-violet ray rooms. Also a social room which may be used as a dining room for semi-ambulatory patients. Leading off each social room is a small library and writing room. In the east ward building is a thoroughly equipped barber shop; and in the west ward building is a dental room with all of the modern appliances for caring for the teeth.

An institution of this size (it readily accom-

modates 200 patients) requires a central power and heating plant, and this has been provided in a separate building about 300 feet from the main hospital buildings, and is connected with them by a service tunnel or subway through which pass the steam pipes and electric cables. This tunnel simplifies the traffic to and from the main hospital buildings and makes possible the unobstructed operation of the complete institution, irrespective of weather.

The engine room contains two 60-kwt. engine generator units, installed for light and power purposes, but the system is so connected that current for lighting may be supplied from it, or in case of temporary failure, from the town of Denver's municipal plant. In the pump room adjoining the engine room are one steam-driven and one electrically driven boiler feed and vacuum pumps, making the possibility of a failure of the heating plant exceedingly remote. These pumps all operate automatically and are connected to a central tank which receives the drainage from the entire heating and power systems and returns it to the boilers. In this room is also located a triplex fire pump, so connected here as to deliver 120 gallons of water per minute at 100 pounds pressure to a hose attached to any one of five hydrants distributed about the hospital grounds. This pump also serves as an automatic booster of the water pressure.

The boiler room contains three 66-inch horizontal tubular boilers in brick settings, and the system of piping is such that either boiler may be run at high or low pressure, or one may be run high and another low at the same time. The plant is designed to heat with the vacuum system and during the heating period the exhaust steam from the engines and pumps is turned directly into the low pressure heating main, furnishing all the necessary heat throughout the several buildings. By this process 100 kwts. of power are obtained as a by-product at little cost of fuel.

Model Hospital Laundry

On the first floor of this building is the hospital laundry, a model of its kind. It is supplied with the most modern machinery and each piece is driven by an individual, direct-connected electric motor, and is protected by safety devices to prevent accidents to operatives. There are sterilizing washers for the patients' clothing separate from another for the clothes of the staff and employees, and these washers are so built and installed that the soiled linen is put into the machines in special receiving rooms and is taken out clean on the opposite side of the washers in the main laundry room.

A. H. A. TRUSTEES LEGISLATE ON CURRENT HOSPITAL PROBLEMS

Better relations between public health administrators and hospitals, cooperation with the Association of American Medical Colleges, the compulsory testing of clinical thermometers, National Hospital Day, and the advisability of inviting representatives from New Zealand to the twenty-sixth conference of the American Hospital Association were the principal subjects considered and acted upon at the last meeting of the trustees of the American Hospital Association.

Approval was given to the appointment of a committee to cooperate with a special committee from the American Public Health Association for bringing about closer relationships between the two organizations. To that end the following resolution was adopted:

Resolved, that the president is authorized to appoint a special committee to cooperate with a corresponding committee appointed by the American Public Health Association in the problem of bringing about a closer relationship than at present exists between the public health administrator and the hospital or dispensary.

The appointment of a member of the association to cooperate with the Association of American Medical Colleges with regard to the time of appointment of interns was approved by the resolution:

Resolved, that Dr. Nathaniel W. Faxon be authorized as the representative of the American Hospital Association to confer with the committee of the Association of American Medical Colleges on the proposition of determining the time of appointment of interns and to report the result of such conference to the trustees with such recommendations as the future action of the joint committee shall see fit to make to the two associations.

The association went down in favor of the compulsory testing of clinical thermometers through the adoption of the following resolution.

Resolved, that the trustees of the American Hospital Association approve in principle the prohibition of the sale of clinical thermometers in the United States, unless tested and approved in accordance with the requirements of the U. S. Bureau of Standards.

A. H. A. Takes Over National Hospital Day

In response to the request that the American Hospital Association assume responsibility for National Hospital Day and the National Hospital Day Committee and its work, the following resolutions were adopted:

Resolved, that the proposal of the owners of *Hospital Management* be and hereby is accepted and recognized as a further evidence of their sincere interest in the welfare of hospitals; and that the Association on May 13, 1924, shall assume responsibility and control for National Hospital Day together with the National Hospital Day Committee and all other organizations developed for the promotion of National Hospital Day, and be it further

Resolved, that the officers of the association are hereby authorized and instructed to assume such responsibility and control.

The declared intention of the New Zealand hospital field to send delegates to the twenty-sixth annual conference of the association was advanced:

Resolved, that the trustees of the American Hospital Association do hereby express their desire that a delegation from the hospital field of New Zealand shall attend the twenty-sixth annual conference of the association in Buffalo, N. Y., the week beginning October 6, and cordially invite such a delegation to come.

A SCIENTIFIC BASIS FOR THE USE OF COLOR IN THE OPERATING ROOM

By PALUEL J. FLAGG, M.D., NEW YORK, N. Y.

WHITE, the ancient symbol of purity indicating always a freedom from moral and physical contamination, was the obvious choice of color in the development of the operating room. Uncleanliness is not easily tolerated upon a polished white surface. It follows that sepsis, microscopic dirt, should be repelled upon the same basis. Not only the profession but the public came to look upon a glazed white surface as the criterion of asepsis.

As surgical intervention became more complex and operations within closed cavities, that is, the pelvis, upper abdomen, nose and throat, became more frequent, the need for special illumination became urgent. Strong light for the operating field was developed and perfected and a difficulty at once became apparent. The amount of light thrown back to the operator from white draperies, white tile floors, white tile walls, white enamel ceiling, was so great that it affected seriously his view of the field of operation. Special types of daylight lamps were introduced to overcome this eye fatigue, but they failed to meet the problem.

Various operators, perceiving the true nature of the difficulty which confronted the surgeon, have advanced suggestions which have afforded relief. On the whole, literature on the subject is scanty and there has been a confusion of viewpoints as to the precise objective. Surgeons, architects, medical men, hospital superintendents, color experts, and others have advanced their views and little attempt has been made to separate the aesthetic from the utilitarian, the psychological from the physiological needs.

Dr. H. M. Sherman of California, one of the pioneers in this country in the use of color in surgical amphitheatres and operating rooms when operating upon the cleft palates in little children, about twenty years ago, began to use around the mouth black cloths in place of the ordinary white toweling with the result that the back of the patient's mouth came into the high

The investigations of experts in the science of color and the experience of surgeons and operating room personnel have demonstrated the incorrectness of the use of white walls, enameled equipment, pure white draperies and toweling for the operating room. Admitting that white is the most suggestive of cleanliness, the traditional use of white on this account may well be sacrificed when the health and efficiency of the worker are concerned. Colors, notably the true complementary color to the operating field, have superseded white in operating rooms where the personnel recognize their superiority as an aid to the conservation of eyesight and the attainment of greater efficiency.

light, greatly facilitating the surgeon's work in the back of the oral cavity. The discomfort experienced by him in the modern white operating room led him to propose the use of dark floors and wainscots, so that the operator who looks up from a wound shall not encounter a glare of light and find his eyes useless for a moment, as he looks back into his less illuminated wound. Green, as the complementary color to red,

blood and tissues, was recommended by him for the color of the floor and wainscot, the green of the spinach leaf being found to be the particular shade of green complementary to hemoglobin.

In the operating suite in St. Luke's Hospital, San Francisco, Cal., the tiles of the floor and wainscot are a dull, dark green, and above the level of the six-foot green wainscot is white tiling to the ceiling, which is a bright buff. The green room is lighted by a transparent glass window which gives a northern light and reaches from about three feet above the floor to the high ceiling. The same dark color scheme was followed out with respect to the sheets and towelings, which were at first provided in green galatea, but as the color in these did not stand the superheated steam in the sterilization, it was decided to surround the whole operating field with black as giving a surface from which no light could be reflected. Besides black sheets and towelings, black gowns were made and the coverings for the instrument tables were all black. The experiments made with this new color scheme are described as exceedingly satisfactory, as the result of the improved optical condition. Operators are found to be partial to the new green and black effect, with the light reflected from the light buff colors of the upper walls and the ceiling.

According to Mr. W. Ludlow of Ludlow & Peabody, architects, New York City, the operating room, because of its highly technical requirements, should have most careful consideration given to its color scheme. When operating, the surgeon must have a great abundance of light

without glare. Therefore, the white glazed tile and white walls, formerly used have largely been replaced by a color and texture with less glare. In one hospital, a soft olive green wainscot five feet high was used, with light color on walls and ceilings. The green is most agreeable to the eyes of the surgeon as he bends over his work, but on raising his eyes a visual shock is caused by the sudden transition from the absorptive green to the reflecting white. Mr. Ludlow recommends a dull French grey tile for the wainscot, and a lighter grey for reflecting surfaces above. Thus, no visual readjustment is necessary to the surgeon, on lifting his head; yet the light in the room is conserved by suitable reflection.

Black sheets and towels are also in use in some Philadelphia hospitals. Black has been adopted by Dr. Alexis Carrel for his animal experiments in the Rockefeller Institute, New York, N. Y. Grey was used in the Rockefeller War Demonstration Hospital. The operating rooms of Dr. R. W. Corwin of the Colorado Fuel and Iron Company, Pueblo, are treated in lead grays.

Professor M. Martens, of the surgical department of the Bethanian Hospital, Berlin, Germany, who in 1906 contributed an interesting paper on the construction and equipment of modern operating rooms, devotes a few words to the color of the walls. A light color, he says, is naturally accorded the preference, not only in the wards, but especially in the operating rooms; but this predilection must not be exaggerated. In the Bethanian Hospital dull ivory-tinted tiles and ivory paint were selected as the most desirable. The floor of the operating room is paved with clay-colored sexangular closely jointed tiles, and the walls are lined with very durable glazed Dutch tiles up to the plaster ceiling, which is painted with enamel color. In the Virchow Hospital, Berlin, the ceilings are covered with ivory-tinted tiles.

Colors Governed by Intensity of Light

In Germany, Kroenig is usually credited with having been the first to recommend the use of color in operating rooms, in order to rest the surgeon's eyes. According to his first suggestion, the walls of operating rooms were to be given a Pompeian red, but he soon recognized that green is a better color for this purpose, and blue was also given a trial. Professor Martens personally prefers green, but points out that the selection of the colors must be governed by the intensity of the light which enters through the windows of the skylight. He says that in Dessau, for example, the large door which leads from the operating room is painted a dark red.

In defense of the white operating room, a number of voices have been raised, notably that of Dr. Wm. Lee Secor, who points out that in an operating room with dark green side walls, onto which light is admitted from one side only, with the addition of a skylight there would be a light side and a dark side to everything in the room; shadow formation would be inevitable. He is of the opinion that white floor and side walls, white sheets, towels and gowns, all play a part in producing an evenly diffused light throughout the whole operating room. Some of the operating rooms which have recently been constructed with dark green side walls, receive 100 per cent of their lighting from one side and reflect only 11 per cent (coefficient of reflection for dark green) from three sides. In the white operating room, about 100 per cent of light enters from one side and 88 per cent (coefficient of reflection for white) is reflected from every surface producing a much more even, general illumination which is better in all but cavity operations. "In eye, ear, nose and throat work, vaginal, rectal, and some deep pelvic work, the field can be better illuminated by concentrated light upon the operative area than by the general illumination of the operating room. For this kind of work dark green or black walls are just as good or probably better than white walls."

In an address on surgical hygiene, asepsis and antisepsis, G. Witzel speaks of replacing the use of white enamel paint for walls (which was found not practical because too delicate) with well-jointed glass plates, covering the walls of the operating room to the height of 1.50 meters, an arrangement which proved very serviceable. The walls of the modern surgical workrooms in the Altona City Hospital, Altona, Germany, according to the description of F. Konig, are lined from the floor to the glass roof with yellowish white glazed tiles, which reflect the light in all directions. The floor is covered with dull white tiles.

While the psychology of color as it affects the operating room personnel is not to be compared in importance to the physiology involved, yet, it deserves serious consideration. It is from this angle that the expert on stage lighting approaches the question of color in the operating room. Mr. Rothafel of the Capitol Theatre, New York, N. Y., is convinced that the operating table draperies, as well as the floor in the center of the room, should be ecru, changing to a delicate green as we approach and ascend the wainscoting. Undoubtedly he is correct in his view of the operating room in the ensemble from an esthetic standpoint.

The operating room must be kept warm, but not oppressively warm. Gray walls, gray or

black draperies are neutral, thus providing no relief. To some, grey and black are depressing. Green, however, is positive in its association with coolness. It suggests the atmosphere of deep water and green trees and reacts favorably upon tension and irritability. The effect of music upon a troubled spirit is a common experience, but the exact relation of color to music is a matter for open discussion. "The Science of Tone Color," by Edward Maryon, brings out this relationship. The Taylor system of color harmony is based upon the application of the laws which govern harmony in music. Maud Miles of Washington, D. C., has developed a color keyboard based on the musical scale. There are also a number of color pianos, some of which are based upon a direct relationship of music and color.

When color has been finally set to the music in the true relationship which all arts bear to one another, then we may apply the silent symphony of peace to the surgeon harassed by the responsibilities which distress him.

Two-fold Problem of Color

The problem of the use of color in the operating room is twofold, namely: the esthetic or psychological, and the utilitarian or physiological. The first consideration has been touched upon. The utilitarian or physiological aspect of the problem now confronts us. Three distinct difficulties are to be met; illumination of the field, reflection from the field and color fatigue. The illumination of the operative field has been the subject of exhaustive work. Curiously enough, we find an unusual situation here. Since modern operating rooms have come into being, there has been a unanimous feeling that daylight is absolutely necessary. The operating room should be placed near the top of the building to the north so that it will compare favorably with an artist's studio. This should be done, regardless of expense. The large plate-glass windows should be so constructed as to open freely, yet, they must on no account be opened so as to allow dust and sepsis to enter.

Perfect artificial illumination must also be provided for night work, early morning work, cloudy days and late afternoons, not to speak of such occasions as nose, throat and ear operations. The writer has inquired of many surgeons with whom he works: "How many times have you operated during the last year by daylight alone?" The answer is quite unanimous: "I can scarcely recall a single instance in which I have operated without artificial light."

The conclusion is obvious. We have unconsciously passed from daylight operating to operating by artificial light. As far as light is con-

cerned, the operating room may as well be in the basement, entirely enclosed save for entrance and ceiling ventilation.

Granting this situation, which certainly exists as far as most city hospitals are concerned, the problem of color in the operating room is much simplified and becomes susceptible to accurate and constant treatment.

How Artificial Light Affects Color

The color of an object depends upon the light which falls upon it. Daylight and sunlight contain the full spectrum. Artificial lights approach this criterion. Many of the so-called daylight electric lamps are highly unsatisfactory from the viewpoint of color. While the author is not acquainted with the various spectroscopic values of these lights, he has many times demonstrated that it is impossible to show the normal color value of oxygenated blood by this illumination, since the yellow and the red in the ordinary bulb have been reduced.

This condition is unusually distressing when one is striving to avoid suboxydation during anesthesia. Light thrown on the same field by an ordinary Mazda lamp will immediately bring out the discrepancy. The patient whose oxyhemoglobin appears to be about 50 per cent saturated under the daylight bulb will be found between 90 and 100 per cent saturated with oxygen when the ordinary light is used. If, therefore, color in the operating room is to receive the attention it deserves, and if efforts at standardization are to be made, we must have uniform illumination. Fortunately, in this particular instance, the best, is the least expensive. The ordinary Mazda lamp gives a satisfactory result.

Indirect lighting, if reflected from a ceiling of ivory or cream, will provide a warm, agreeable and effective illumination of the operating room. The field of operation should be illuminated by a battery of Mazda lamps. The intensity of the illumination is restricted by the heat evolved and the distress caused by reflection from adjacent white surfaces. Heat may be relieved by a suitable air suction fan installed near the ceiling and connected with the central light. Intense reflection from a white surface reduces, and may temporarily paralyze color vision. Looking at sunlight makes everything about us appear black. Many efforts have been made to meet this difficulty. Sherman of California with his black draperies; Carrel with his grey; Corwin with his lead colors; Virchow, ivory; and Sherman with his spinach green. Relief has been found by these investigators in the employment of color to limit reflection.

Sherman's selection of the spinach leaf green was the first step in solving the physiological problem of color fatigue in the operating room. But the color of the spinach leaf varies with age, and the color of the blood depends upon its relative oxygenation, not upon a constant hemoglobin, so that Sherman's conclusion failed of wide adoption because it could not be advanced upon a solid basis of scientific precision. Through the help of many kind friends, notably, Dr. D. D. Van Slyke and Dr. Carl A. Binger of the Rockefeller Institute, for Medical Research, the author was enabled to produce an oxyhemoglobinometer by which the color of the blood can be measured in terms of oxygen saturation. One extreme of this measure of oxygen unsaturation or cyanosis, is that of 100 per cent oxygen saturation (zero cyanosis). Blood exposed to atmospheric air promptly approaches complete oxygen saturation. The major portion of the free escaped blood in a wound, in the toweling and the draperies is 80 to 90 per cent saturated. It is only the occasional clot of venous blood that is darker, but for practical purposes this does not represent the color of the field as a whole.

The above observations have already been recorded.* The hemoximeter or oxyhemoglobinometer of the author, therefore, provides a scientifically accurate, constant criterion by which we arrive at the color of the field of operation. By means of the Munsell system of color notation the true complement of the color of the field of operation as determined by the hemoximeter has

*"An Oxyhemoglobinometer for the Clinical Measurement of Cyanosis," Proceedings of Soc. for Exp. Biology & Medicine, 1922, XIX, pages 2 to 5.

The question has been proposed: "Why are complementary colors more restful than other colors?"

Complementary colors are less fatiguing than others because the complementary color is the only color which does not repeat the original. The normal eye is receptive to all the colors of the spectrum. This is proved by the well-known test of gazing steadily on a red cross on a white field; then allowing the gaze to fall on a plain white field, upon which will be seen, appearing gradually, the complementary green cross. The red cross, as it were, burns a temporary cross-shaped area on the retina, making it blind to red. When the gaze is dropped to a white surface (which is a full spectrum) the area which has been blind to red through fatigue, will, however, register the balance of the spectrum, represented by the complementary green.

If the above be granted, it follows that we can best conserve our vision for red by limiting these rays exclusively to those proceeding from the blood in the field. As white and grey both contain red, they are more fatiguing than the only color which does not contain red; namely, the true complementary green.

Imagine a terrestrial globe. The axis passing from the north to the south pole is the dimension referred to as *value*. The north pole is represented as pure white, the south pole, black, the intervening portions are made up of grey, lightest at the north, darkening to black at the south. The equator represents *hue* or the spectrum, red, orange, yellow, green, blue, violet.

All hues on this equator are of the same intensity. Imagine radii proceeding from the equator to the center of the sphere from each color. These radii represent *chroma*, the third dimension. Chroma is intensity of hue. As a red (hue) approaches the gray (value) it becomes more grey and less red. The color exactly opposite any other color on the equator is its complement, and if mixed or spun with it, produces a neutral grey.

If the opposite color is not the true complement it will never produce neutral grey, no matter how the proportions are varied. From the foregoing it will be seen that a grey green (a green half way down the radius) while a true complement to the opposite red (on the equator) will need to be present in a larger volume (or surface) to completely neutralize the more intense red. In other words, a true complementary color (the true green complement to 90 per cent oxyhemoglobin) may vary in several respects and still be a true complement (provided that the hue is constant.) First, there may be a large surface of a light green chroma to complement a small surface of high red chroma; second, equal areas of equal chroma may be used, or lastly, a small field of high green chroma may be used to neutralize a large field of relatively low red chroma.

been secured. This complementary color is a peculiar bluish green, presenting a soft and rather soothing background and intensifying the color of the tissues.

The successful use of complementary colors is not generally understood. A complementary color always intensifies its opposite, rendering the sharpest possible contrast. The use of the port (red) and the starboard (green) light is not accidental. It is because these complementary colors provide an easily discernible difference. The setting sun over the green summer waves, the extraordinary brilliancy of the scarlet tanager or crimson poppy in its background of green, all bear witness to the value of the complement. On the other hand, to gaze for a moment upon the sun's full spectrum or to be exposed to its undimmed reflection from fields of snow or broad summer beaches is to experience color fatigue for all the colors of the spectrum, the result being the absence of hue value and chroma denoted by blinding blackness.

The Munsell system of color notation has made it possible to ascribe three qualities or dimensions to color. On the basis of this system, any color or shade may be expressed by a formula and accurately reproduced without direct reference to the original.

Obviously, our specific problem calls for a relatively large surface of low green chroma to balance the small area of high red chroma represented by the operating field.

The true complement for 90 per cent oxyhemoglobin is a peculiar shade of bluish green. The chroma of the green is relatively low, 65 per cent green, 35 per cent red. The proportion of green may still be lower but will remain complementary because of the relatively large area of draperies as compared to the red field of operation. The repeated sterilization of the draperies will gradually bring about the lighter chroma previously mentioned.

Recalling the results of previous investigators, we find that:

Illumination has been unnecessarily complicated by the assumption that daylight is essential to the field of operation, that pure white draperies, furniture, toweling, and walls are conducive to microscopic cleanliness and by reason that the light reflected offer a diffused illumination which indirectly acts as a germicide.

Reflection Caused by Artificial Light

Reflection from white surfaces constitutes a serious difficulty which has increased as the use of artificial light has taken the place of daylight.

Reflection from white surfaces has made it impossible to use a maximum illumination without further obscuring the field by reflection. To relieve annoyance caused by this reflection, color has been employed; black, gray, ivory, lead, Pompeian red, blue and spinach green have been employed with more or less satisfaction. Color fatigue has been recognized and a spinach leaf green has been suggested.

However, in a careful search of the literature there is no record to indicate that the exact color of the field of operation is recorded and available by instrumental mensuration or that a scientifically proven complementary color has been secured and may be duplicated with accuracy.

Through the indispensable assistance of the members of the surgical staff of St. Vincent's Hospital, New York, N. Y., and by reason of the patience and charity of the Sisters in each of the operating rooms, the writer has been enabled to crystallize and to put into practice the views above outlined. The use of the true complementary green in the operating room draperies has afforded exactly the relief desired.

White Operating Room Proved Incorrect

A white operating room while suggesting cleanliness, asepsis and a pleasing aspect from an esthetic point of view has been found scientifically and physiologically incorrect.

Suggestions bearing upon necessary deviations from white have come from all classes of persons, surgeons, medical men, architects, interior decorators and stage lighting experts.

No attempt has been made to allow for the specific point of view and to place these suggestions as coming from two distinct groups: first, those interested in the ensemble of the operating room (views aesthetic and psychological) and second, those interested in the operating room as a laboratory with an interest focused upon the field of operation (views utilitarian or physiological). The operating room is merely a setting for the patient and the field of operation, therefore, the physiological point of view must predominate.

The difficulties presented by the field of operation are three: illumination, reflection, and color fatigue. Operations are but rarely performed by the exclusive use of daylight. Consequently, the problem of supplying daylight for the operating room has passed. The operating room may as well be in the basement of the building. The ordinary Mazda light with yellow rays is better than the so-called daylight bulb.

Reflection should be met by green draperies, gowns, toweling and wainscoting with walls and ceiling of ivory or cream.

Color fatigue is met by employing the true

complementary color to the operating field; a definite bluish green color. The color of the operating field has been determined as equal to about 90 per cent oxygenation. (Oxyhemoglobinometer, Flagg). This complement is proved to be true by spinning with the red to a neutral gray. In practice, the complementary green permits of maximum illumination and disposes of the problem of reflection and color fatigue. It is recommended that all draperies, gowns, gauze, etc., be of this particular hue. That, where possible, operating furniture be painted accordingly, and where new hospitals are being built, that floor, wainscoting and tiling, based upon this hue, be employed.

Arrangements are being made with responsible firms to provide material of this scientifically accurate, complementary green.

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TO COLLECT DATA ON DISEASES TREATED IN HOSPITALS

The information bureau of the United Hospital Fund has undertaken to collect the main medical facts about every patient discharged from the New York hospitals in order to afford a definite picture of the amount and kind of illness treated in the hospitals. It is expected thus to find a basis for the determination of such significant factors as the distribution of racial and occupational diseases. Also, according to a statement issued by William Fellowes Morgan, president of the fund, the public interest created by the publication of such facts would increase the demand for hospital service. *The Nation's Health*, May 15, 1924.

A study of the fees now charged by dispensaries and a study of methods of financing hospitals will be undertaken by the American Hospital Association, according to the resolutions passed at the last meeting of the board of trustees of the association.

THE THORNDIKE MEMORIAL LABORATORY OF THE BOSTON CITY HOSPITAL

By MAGINNIS & WALSH, ARCHITECTS, AND JOHN J. DOWLING, M.D., CONSULTANT, SUPERINTENDENT, BOSTON CITY HOSPITAL, BOSTON, MASS.

"THE opening of the Thorndike Memorial Laboratory marks an epoch in the conduct of municipal hospitals. It is the first recognition by a municipality of the practical value of research, and this recognition in itself is a lasting tribute to the vision and philanthropy of the donor." These were the words of Dr. William J. Mayo, at the dedication exercises of the new building of the Boston City Hospital, November 15, 1923. As its name suggests, the building will be devoted entirely to research in medicine.

This new laboratory was made possible by a bequest of the late Hon. George L. Thorndike in memory of his brother, Dr. William H. Thorndike, who for a quarter of a century was visiting surgeon to the Boston City Hospital. When this bequest of \$250,000 became available, the trustees of the hospital decided to use this sum in the construction of this laboratory building. To this sum the City of Boston added \$250,000, thus enabling the hospital to erect the new \$500,000 building.

The building has four stories above the basement with a total length of 145 feet and an average width of fifty feet. The design is an adaptation of the Georgian style of architecture. The exterior walls, to the level of the second story window sills, are of brick faced with Standard Buff Bedford stone and all walls above are of red water struck brick laid in Flemish bond, with all trimmings, belt moulding and cornices, of Standard Buff stone. The roof is flat, covered with tar and gravel.

The main entrance is from the hospital side, where a simple, dignified stone doorway is provided. The principal façade faces on East Concord Street. There it is enriched by a stone col-

onnade with Ionic columns bearing an entablature, on the frieze of which, in incised letters, is the name of the building. The exterior steps are of granite.

All interior partitions are of terra cotta, which is also used for the lining of exterior walls. Partitions between rooms are of hollow tile, easily removable, so that the various laboratories can be enlarged at will. The foundation consists of caisson piles under walls and interior columns, the former being carried between piles on reinforced concrete girders below grade. The floors and the flat roof are of so-called "long span" reinforced concrete construction, concrete joists

separated by corrugated steel filler tiles resting on the masonry walls and on longitudinal girders carried by the concrete columns. In the large panels over the lecture hall this construction spans in both directions the entire width of the building.

The interior staircases are of iron with slate treads and landings of terrazzo with slate base and borders. The finished toilet room floors are of terrazzo with terrazzo base. The finished floors of other rooms are of linoleum cemented down firmly on a cement under floor.

Grey Tennessee marble is used for dadoes and partitions in all toilet rooms. All wood for cases, drawers, etc., used in the interior of the building is of straight oak.

At the Concord Street end of the basement and first floor is a medical amphitheatre seating 140 persons.

On the plans the original designations of the various rooms in the x-ray department have not been changed, but several rooms are used for purposes other than those originally intended. The basement is devoted to x-ray for house cases and such out-patients as may be in need of special



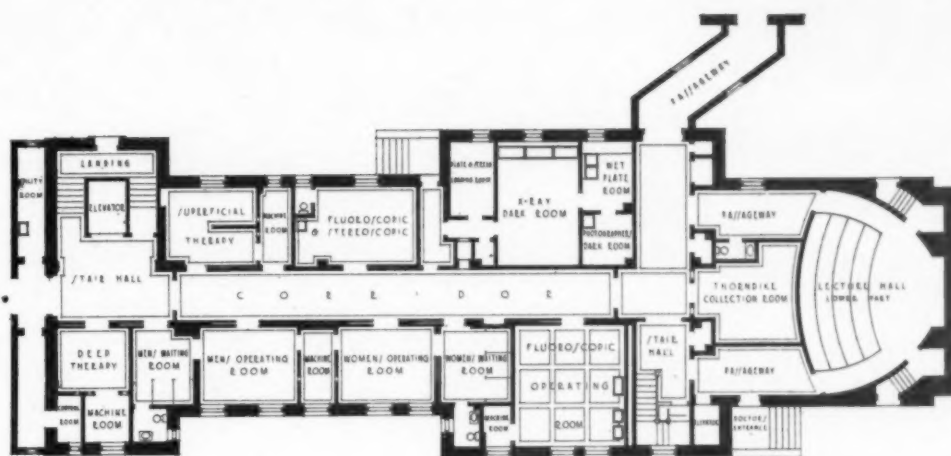
Front view, Thorndike Memorial Laboratory.

treatment. The first floor contains waiting rooms, dressing rooms, x-ray operating rooms for out-patients, plate illumination room and record rooms, as well as offices for the physician-in-chief and his assistants.

The recommendations of the safety committee of the American Roentgen Society have been complied with. Accordingly, (1) there is no one machine furnishing power to any two rooms; (2) all the rooms, except one, are exposed to constant sunlight; (3) there is ample ventilation in every room; fresh air enters through a lightproof maze above every window frame; moreover, each room has an outlet ventilator, connected with an electrical blower, which pulls out the used air, thus insuring a constant change of air. In addition, all rooms are surrounded with one-eighth inch sheet lead concealed in the walls, to a height of seven feet, except the room for deep therapy, the ceiling and walls of which are sealed in one-half inch lead.

Each Room a Complete X-ray Unit

Each room is a complete x-ray unit and can be used for routine radiographic and fluoroscopic work, and four of them may be used for superficial therapy. Each room is wired directly to the main switchboard so that electrical trouble in any one room will not affect any of the others. Sliding barn doors are used throughout which prevents interference by swinging doors with



BASEMENT FLOOR PLAN

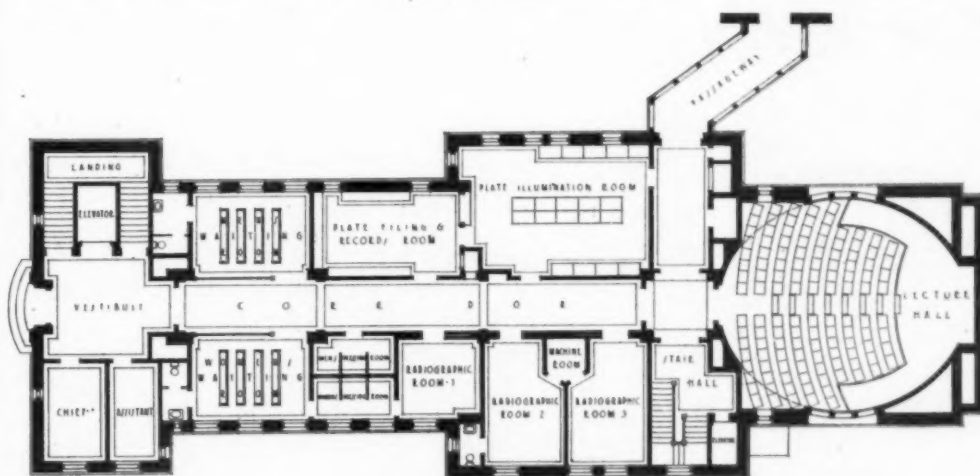
litters, bed and wheel chairs. A separate generator has been installed in the power house for furnishing alternating current which is supplied to the x-ray department alone, insuring an even and constant electrical supply.

Three Top Floors for Clinical Research

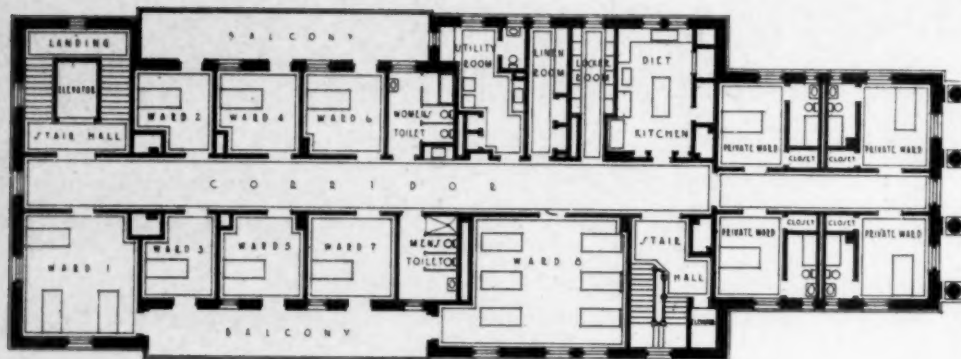
The three upper floors are devoted to clinical research. The second floor consists of a ward of nineteen beds to which patients drawn from the general hospital for special study and for investigation will be admitted, and two large sun balconies to which every patient has access. In the large ward there are six beds and in the four smaller private wards, one, two or three beds. There is an office for the supervising nurse and a small diet kitchen in which special foods can be prepared.

The third floor of the building is devoted to laboratories except for the offices of the director, —consisting of secretary's room, study, examining room, and a conference room, which is used for the staff and for a small working library.

Between the conference room and the large chemical laboratory is a small room in which a heavily constructed titration rack has been placed and in which there is an electrically operated refrigerator. The chemical laboratory is fitted with three long desks and has working space for from six to ten men. Opening from it, at one end, are a dark room and a balance



FIRST FLOOR PLAN



SECOND FLOOR PLAN

room, and at the other end is a room for Kjeldahl determinations, for glass blowing, and for carpentry.

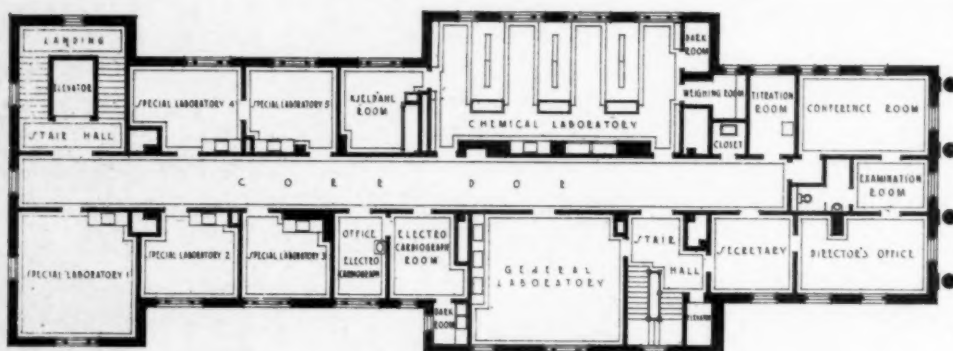
Next to the latter are two small laboratories for one or two workers each. These are at present being used for special studies in hematology and gastroenterology. Across the hall from the chemical laboratory is a large laboratory for three workers, and next to this is a series of three rooms for the electrocardiograph — an office, a room for the instrument, and a dark room. Beyond are two small laboratories for one or two men and a large corner laboratory which will be used for metabolism work and studies on respiration.

The fourth floor is also given over to laboratories. Next to the main staircase are three rooms for bacteriology, and directly over the main chemical laboratory is a large store room. The two laboratories beyond this are to be for physiology and pharmacology. Opposite this, on the southeast corner, is a small

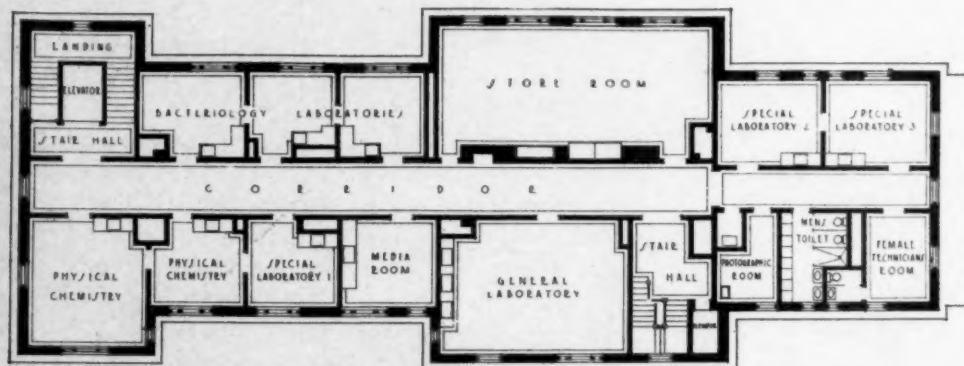
storing culture media is placed. Next to this comes another small laboratory for bacteriology and then two rooms which are being devoted to physicochemical studies of the blood.

On the flat roof of the building there is a small animal house.

With the exception of the desks in the chemical laboratory, almost all of the furniture of the



THIRD FLOOR PLAN



FOURTH FLOOR PLAN

rest room for women technicians, a toilet and a small room which will be used for photography and photomicrography. Beyond the staircase there is a large laboratory which will provide space for at least three workers. The next room is a media room in which the apparatus for making and sterilizing and

building is movable and interchangeable. It is thus possible to change the character of any laboratory and adapt it to the needs of new workers. In addition to ordinary plumbing, the laboratories are equipped with gas, compressed air, vacuum, direct and alternating electrical current, high voltage current, and compressed steam.

TO REVIEW BED SURVEY

The U. S. Department of Commerce has arranged for a general conference June 3, to review the findings of the survey on hospital beds that has been made by the committee on general furnishings and supplies of the American Hospital Association.

THE HOSPITAL'S COAL PROBLEM*

BY JOHN C. DINSMORE, PH.B., PURCHASING AGENT, UNIVERSITY OF CHICAGO, CHICAGO, ILL.

BRIEFLY, the coal problem of the hospital superintendent is to find the coal which, in combination with his plant and his workmen, will deliver the maximum number of heat units per dollar expended. The field from which he may draw his fuel may be pretty definitely determined for him either by his boiler equipment, by his particular location or by the local smoke ordinances.

However, this does not mean that he may safely fail to survey his whole problem and to check accurately every possible source of supply. Frequently, a comparison of the cost of heating two institutions in the same city will show that the fuel cost in one is materially less per thousand cubic feet than the cost for the same area in the other. This difference may be due to many things, but is often due to failure properly to coordinate those three factors—fuel, plant and man power.

Problem Needs Annual Restudy

It is a good plan to restudy the whole problem from the ground up every year. Covering the same ground may seem like an unnecessary expenditure of time and energy, but it usually pays and pays handsomely. Perhaps the best first step is to take the last issue of the "Coal Catalogue" and the most recent publications of the "Bureau of Mines" and pick out all the coal samples that show an analysis better than the average. After listing these good samples as possibilities, the next step is to compare the delivered cost of the various coals. Some of these coals may be so much better than the average that they will command a premium which may or may not more than offset their apparent advantage. Some samples will be eliminated because of uncertain transportation conditions and some because the fusing point of the ash may be unduly low. You may find that the entire output of the most promising coal mines is taken up by certain steel mills or cement plants.

After you have made these eliminations, you

Coal purchasing constitutes one of the most difficult problems which confronts the hospital purchasing agent. It is a problem which needs to be thoroughly studied each year by the individual hospital. Intelligent purchasing calls for the study of the latest issues of the recent publications of the Bureau of Mines and the collection of samples which show a superior analysis. Another factor to be considered is the delivered cost of the various coals. Then it remains for each hospital to try out the coals in its own boilers. If a careful record is made of these tests, it is easy to select the one or two samples which show promise of producing the largest number of heat units per dollar.

may still have left from three to ten possibilities. The next step is to try out these coals under your own boilers with your own operating conditions. If a careful record is kept of the tests made, you will be able to pick the one or two samples that promise the largest number of heat units per dollar in a form that is usable. After you have covered all this ground you may find that the coal you used last year is best

suited to your needs or you may find that the product of another mine is better for your purpose. Whatever decision you reach, you will at least have the satisfaction of knowing that your coal business will be placed not as the result of guesswork, but rather as the result of a careful canvass of the whole situation.

The "B. T. U." Purchasing Contract

Many of our readers have no doubt often wondered why it is not advisable to purchase coal on a "B.T.U." or heat value basis, since the heat units are what we are trying to purchase. Theoretically, the "B.T.U." contract is the only scientific basis for the purchase of any coal, but actually it does not often work out to the advantage of either the purchaser or the coal dealer. The principal difficulty experienced in such a contract is due to the fact that coal is not a manufactured product and the heat content is, therefore, not uniform, and the mine operator cannot control this lack of uniformity. Since this is true, the coal man must necessarily add enough to his contract price to insure him against a possible loss. This immediately increases the mine price by at least 10 per cent.

Since under the "B.T.U." contract a sample from each car of coal must be analyzed in order to determine the number of heat units the coal contains, the cost of making analyses (from \$5.00 to \$7.50 per sample) adds a further burden of ten to fifteen cents per ton. Then, too, someone must carefully collect and prepare each sample, and this again adds from two to three cents per ton to the cost of the coal. The total additional cost of buying coal on a "B.T.U." basis is, therefore,

*This is the third of a series of five articles on hospital purchasing prepared for THE MODERN HOSPITAL by Mr. Dinsmore, purchasing agent, The University of Chicago, Chicago, Ill.

from twenty to thirty-five cents per ton.

Even if the hospital superintendent were willing to stand this extra cost in order to have the satisfaction of knowing just the amount of heat he was getting for his money, there would still be no satisfaction in the "B.T.U." contract. A great deal depends upon the way in which the sample is taken. Sampling is important, but it is also a dirty disagreeable job, and is ordinarily done by rather low-grade attachés of either the laboratory or the boiler room. Since this is true, these men are apt to be careless either in taking or in preparing the sample, with the result that the report of the laboratory may not represent the actual heat value of the coal.

Danger of Unfair Test

There is also always present the unpleasant possibility that these low-grade employees may be influenced so that the sample they turn in to the laboratory may not be fair. The sample may be too good and the man who has the "B.T.U." contract may pay a premium when none was earned, or the sampler may be annoyed with the coal dealer or just be feeling out of sorts and turn in a sample which contains an unfair amount of rock or shale.

Even though the samples are taken carefully and fairly, you must still reckon with the possible inaccuracy of the laboratory. To the layman this does not perhaps seem probable, but the fact remains that inaccuracies do sometimes creep into the laboratory. Then too, there is usually a rather wide difference between the analysis of the two halves of the same sample. The Chicago, Willmington & Franklin Coal Company has prepared a chart showing the variation in the price to be paid them for coal purchased by certain Illinois state institutions based upon the analysis of the halves of the same group of coal samples. When these variations were charted they ranged from a penalty of 2 per cent per ton to a premium of 8 per cent per ton.

Procedure Not Always Practical

For the above reasons the "B.T.U." contract is just another instance of a procedure which is theoretically correct, but does not work out in actual practice.

Perhaps the most common source of loss to the hospital is in the substitution and mixing of grades of coal, and to the all too common practice of short weights. The purchase of coal represents such a proportion of the total cost of operating the hospital that it is necessary to provide the means to check both the quality and the quantity of coal actually delivered to the boiler room.

VETERANS' BUREAU SELECTS MEDICAL AND HOSPITAL CONSULTANTS

Congress has been asked to pass legislation that will wipe out the inequalities now existing in the medical personnel of the U. S. Veterans' Bureau and to provide pay and living incentives that will attract the very highest grade of medical skill into the bureau service, according to an announcement made today by George Frank T. Hines, director of the bureau.

Director Hines called attention to the fact that the bureau's doctors were now of three classes, those with civil service status, those holding commissions in the public health service, and the special experts appointed by the director.

Under one bill now before Congress, prepared by the bureau at the request of the house committee on World War veterans' legislation, there will be established a permanent medical corps in the Bureau with commissioned personnel. Another proposal under consideration will create a reserve corps under the public health service, of which the medical personnel of the veterans' bureau will be a part. A third suggestion is that of placing all of the veterans' bureau doctors on a civil service status.

"The giving of medical attention and care to our disabled soldiers will continue for a long time," said General Hines. "It is my desire to build up a permanent high grade medical personnel and to that end I am asking Congress to pass the necessary legislation."

Director Hines announced that he has invited more than thirty of America's leading medical men to act as expert consultants to the bureau.

The following consultants in tuberculosis were selected: Dr. Edward Robinson Baldwin, Saranac Lake, N. Y.; Dr. Wm. Leroy Dunn, Asheville, N. C.; Dr. Kennon Dunham, Cincinnati, Ohio; Dr. Roy Adams, Washington, D. C.; Dr. James A. Miller, New York City; and Dr. Francis M. Pottenger, Monrovia, Cal.

As consultants in neuro-psychiatry, General Hines invited Dr. Wm. A. White, superintendent, St. Elizabeth's Hospital, Washington, D. C.; Dr. Albert M. Barrett, superintendent, State Psychopathic Hospital, Ann Arbor, Mich.; Dr. Wm. F. Lorenz, Wisconsin Psychiatric Institution, Madison, Wis.; Dr. C. Macafe Campbell, medical director, Boston Psychopathic Hospital, Boston, Mass.; Dr. Glenn E. Myers, Los Angeles, Cal.; Dr. Sidney Isaac Schwab, St. Louis, Mo.; Dr. Thomas Salmon, New York, N. Y.; and Dr. Daniel Joseph McCarthy, Philadelphia, Pa.

In general medicine and surgery, the director selected the following: Dr. Frank Billings, Chicago, Ill.; Dr. George Morris Piersoll, Philadelphia, Pa.; Dr. W. J. and Charles H. Mayo, Mayo Clinic, Rochester, Minn.; Dr. George W. Crile, Cleveland, Ohio; Dr. Lewellys Barker, Johns Hopkins University, Baltimore, Md.; Dr. Simon Flexner, Rockefeller Institute, New York, N. Y.; Dr. Ray Lyman Wilbur, president, Stanford University, Palo Alto, Cal.; and Dr. Joel Ernest Goldthwaite, Boston, Mass.

General Hines selected the following consultants in hospital planning and construction: Dr. George H. Kirby, Psychiatric Institute, Ward's Island, N. Y.; Dr. S. S. Goldwater, superintendent, Mt. Sinai Hospital, New York City; Dr. M. T. MacEachern, Chicago, Ill.; Dr. Winford H. Smith, Johns Hopkins University, Baltimore, Md.; Dr. L. H. Burlingham, St. Louis, Mo.; Dr. W. C. Rappleye, New Haven Hospital, New Haven, Conn.

Mr. Michael M. Davis, New York, N. Y.; Dr. Douglas A. Thom, Boston, Mass.; and Dr. Livingston Farrand, president, Cornell University, Ithaca, N. Y., have been selected as consultants in dispensaries and out-patient clinics.

THE USE OF ILLUSTRATIONS IN HOSPITAL PUBLICITY*

BY RALPH WELLES KEELER, COUNSELLOR IN PUBLICITY, BOARD OF HOSPITALS AND HOMES OF THE METHODIST EPISCOPAL CHURCH, NEW YORK, N. Y.

VISUAL education is the great term set before us today. The steady stream of people coming from moving picture houses is evidence that those who use this term know that they are right in their conviction. It is generally true that if we can get any bit of information either from moving or still pictures we seem to prefer to do so rather than wade through columns of oftentimes poor type and worse composition to obtain practically the same information.

In some cities daily newspapers are being published in which two-thirds of the space is given up to photographs of the news, enough type being used to give such added information as the pictures themselves are unable to convey. All over the country Sunday newspapers are featuring rotogravure sections, in which the very finest of photographic art is reproduced in sepia tones. And those daily papers which do not go to the extreme of the "picture dailies," usually print at least a page of "the day's news in pictures." While magazines use an increasing number of illustrations apart from those used to interpret a story or an article.

If the one in charge of the publicity for the hospital will study the advertising carried by magazines, he will soon discover that the wide-awake advertiser uses picture material in a most effective way. A careful study of the pages of this issue of THE MODERN HOSPITAL will demonstrate the truth of this statement. While a reading of the fourth edition of THE MODERN HOSPITAL Year Book will add further force to what has been said.

Since hospital publicity is advertising for the purpose of "selling" the hospital idea and service to the public, it is good business to try every publicity method which is bringing results in the business world, if it has hospital publicity possibilities. And the use of photographs and draw-

Where there is a choice, most of us seek information through pictures rather than exert ourselves to read word pictures in print. Modern publicity has capitalized the psychology of pictures in arresting attention, as is evidenced by the art of photography now prevalent in good advertising. When wisely used, pictures are invaluable in hospital publicity. But, as Mr. Keeler points out, they are too often used merely as pictures without consideration of their definite purpose in describing certain hospital activities which are more appealing when presented pictorially. Thus if pictures are to serve their purpose the whole science of photography and its use in publicity need careful study.

ings not only has hospital publicity possibilities, but also has been put to the test with most excellent results.

Those hospitals which have used photographs most and to the best advantage have discovered that picture publicity attracts attention as no other kind of publicity possibly can. It also suggests more than mere words. Both writers and speakers—in the hospital field as well as in other fields—frequently

say: "I wish I could take you with me through one of our wards, so that you could see these patients, or into our operating room when our surgeons are at work so that their great humanitarian service would be *real* to you." The photograph does this thing which is so greatly desired. And it leaves a definite impression which is easily recalled. Next to an actual visit to the hospital comes the photograph as an aid to making the work going on within its walls something more than a day's task for a given number of men and women.

What the Camera Sees

The indiscriminate use of photographs in hospital publicity does not of itself insure success. There are hospitals which have used pictures with atrocious results. This has been due to the fact that not every one is a good photographer any more than every one is a good publicity man. Pictures out of focus, with too much background or foreground, with the important part of the picture overshadowed by something of minor importance, with people grouped with about as much life as a row of cigar store Indians,—indeed, pictures with almost every conceivable defect, have been used. For the camera sees what is before it and reproduces what it sees with brutal frankness.

Therefore engage a first-class photographer. Have him make a tour through the hospital with the publicity man in order to discover what the picture possibilities are before starting to take

*This is the twelfth of a series of articles on hospital publicity prepared for THE MODERN HOSPITAL by Mr. Keeler.

the pictures. List these possibilities and study them a bit. Seek counsel from the heads of the different departments, who may have something worth while to suggest out the day's work—things which might not come to the attention of either the photographer or the publicity man. Review the listed possibilities in the light of all these suggestions. Study the photographs used by other hospitals and see if they have anything you have failed to discover.

Selecting the Right Pictures

The natural thing would be to start in and photograph everything on the list. To do this would be unwise. For one of the first principles in securing photographs is to foresee their value before taking. With the list in hand go over the publicity survey suggested in an earlier article. This survey will take on new life with the picture list in hand. Check off the picture possibilities which the survey calls for in order to make a more effective presentation of the publicity possibilities listed in the survey. Then use this check-up as the basis for the first lot of pictures to be taken. If it is convenient to do so, ask a newspaper photographer either to make the tour of the hospital with you or to go over your check-up with you and make suggestions as to just what the composition of the pictures should be.

It is in the matter of the composition of the picture that the mistake usually occurs. Only few have given attention to this. Many, after discovering excellent picture possibilities, have failed to score merely because they "took a picture." What is wanted is the "taking of a story," which is quite another matter. The long rows of stiffly starched nurses, the staff members draped on the front steps, all the ambulances lined up side by side,—such pictures tell no story, unless it be that the photographer was merely a "picture taker."

The nurses can be so grouped so as to give an air of reality to the picture, and the staff can be "taken" during one of the staff conferences held for the purpose of discussing the recent deaths in the hospital, or in a setting that would give the same effect. The ambulance picture might better have but one ambulance photographed in some side alley where an accident case is receiving first aid. As much action as possible should be in every picture. The picture of a firemen's parade receives little attention except from admiring members of the firemen's families. But a fire company "tearing" down the street on its way to a fire or firemen busy rescuing people from a blazing tenement is looked at most intently by every one seeing it. And what's more it is re-

membered. The same thing holds true in hospital pictures for publicity purposes.

It is always difficult to get people whom you want to use in a picture to understand why you do not want their face to appear every time. They do not understand why you should want a back view of them. There are times, of course, when the individual should show as himself or herself, such as interns finishing their courses, nurses graduating, the staff, distinguished visitors, and important persons participating in corner-stone layings or dedications. All such pictures have a value because of who is in them. Though in the case of the laying of the cornerstone, only one or two of the participants should face the camera. The remainder of the group should be standing as if there was no such thing as a camera around. Every one has seen pictures where some unimportant bystander has accidentally slid into the picture and faced the lens, and has spoiled the effect.

"Stage" Pictures to Give Effect

Most pictures taken for publicity uses are for the purpose of telling a story. Therefore, every one in the composition of the picture must be so "staged" as to give the final effect of some actual scene in the work of the hospital. The scene in the operating room is for the purpose of picturing the way an operation is performed, the garb worn by surgeons and nurses, and the layout and equipment of the room. Necessarily the individuals photographed should turn their attention to their work rather than on the camera. Some of those in the picture will show only in part. But the story will be there. And that is what those who will be attracted by the picture want to see. A nurse with four babies in her arms may give a picture which the nurse will prize, but a picture of a nurse weighing a baby or handing it to the happy mother in her hospital bed, will be admired by thousands, even though it be a back view of the nurse and only the mother and baby are in the "spotlight." The doctor and nurse at the bedside of a ward patient means that some one of the three must be sacrificed as to prominence. But the three together make a picture that tells a story to the wayfaring man who looks at it in the newspaper or in a booklet. It is the story the picture tells that counts. And the setting should be such that the story "gets across" with the least possible need of word explanation.

Seldom should a photograph be taken without someone in it. The effect is cold and somber. The presence of even one person gives a human touch to the building or room that is photographed. Not many people are interested in

buildings or rooms as such, but are primarily interested in people. But attracted by the people in the picture they must of necessity see the building or room. This is a simple matter, but is one that is often overlooked in picture taking.

The moving picture has shown us the value of the "close-up." This kind of picture holds a large place in pictures of hospital life. Foreground and background can easily be eliminated. The nurse and baby can be brought right out on the surface of the page. The doctor taking a pulse can be pulled out from the dim recesses of the hospital ward, so that when used as inserts in other photographs which take in a long perspective, these "close-ups" help to give life to the whole layout.

Applying the Check-Up

In general, the photographs taken will be used for annual reports, booklets, leaflets, posters and newspapers. Many annual reports would be livened up and made more attractive and instructive if good pictures of the departments of the hospital and scenes from the activities of each day were scattered throughout the pages. The annual report of the New England Deaconess Association, which has a hospital in Boston, has used pictures profusely this year. They are full-page half-tones which carry one through the entire work which the association is doing. Some of the most striking pictures are those of the main storeroom, which looks like a full-fledged grocery and department store; the medical laboratory, which immediately causes one to wish to learn of what is done there; the electrocardiographic apparatus; the medical metabolism room with a patient under treatment; the preparation room on the surgical floor; the doctors' consulting room; the clinic operating room (which should have been peopled); and the graduating class of nurses. But this report only suggests what can be done with a little thought and expense. And the expenditure of both are well worth while, for this report will be perused over again and again because of the good illustrations that are in it.

The hospital booklet can hardly exist without good pictures. Take the booklet suggested in the article "Publicity Through Booklets and Leaflets" (September, 1923, page 457). This booklet, "A Trip Through Mt. Sinai" (the name of the local hospital to be used in each instance), calls for illustrations which will run parallel to the text. And the pictures often keep the reader at his reading until the last page is finished. Booklet covers need good pictures, and each one demands a picture more attractive and striking than the

last, for sameness in pictures is detected instantly. "We've seen that before" will be the reception a booklet receives unless this necessity is recognized.

Pictures for Posters and Leaflets

And what of pictures for leaflets. Often the picture is the chief teller of the tale in a four-page leaflet. This means that it must be a genuine story-teller, which all too many hospital pictures are not.

The poster usually has but one picture. It must be large, with few people in its composition. For one must "read" this picture as he runs. A side glance as one passes, is all that it gets at first. But if it have real pull in it, the observer will stop for a closer view or come past it again to get another look at it. It will become a topic of conversation. Naturally it may become that if it is poor, but in that case the conversation will not be the kind a hospital covets.

Newspapers will use a great many pictures provided they are good. But they will not use old pictures. They are out for news. To be useful to the newspaper, pictures must be newsy and up-to-the-minute, for they often wish to give a striking setting to the picture. And when they ask for a certain type of picture lose no time in having it taken for them, as their need is your opportunity. Too many institutions cooperate only when the approach and necessity comes from themselves.

Avoid Deadening Captions

Many a good picture has been "killed" so far as any usefulness is concerned, by a poor caption. One is sometime reminded of the set phrase of the itinerant stereopticon lecturer of boyhood days, who edified the audience by such enlightening comments as "This is a picture of a geyser" and "The next picture is of another geyser." For the caption which reads "This is a picture of some of our children in the Children's Ward" is of the same school as the itinerant lecturer. Far better is some such human appeal as "Afternoon Tea (?) For Four Year Olds At Mercy Hospital" (though this could be improved). A good caption is worth a half day's study. For if it is good it will earn that half-day's pay over and over again, and, if not good, it might better have never been set in type.

There are some hospital executives—and those in other institutions—who think that after the picture is taken, all is over but the admiration of friends for the fine booklet produced. They forget that the half-tone must be ordered and made. "The office boy can do that," says someone. If

he only could! The trouble is that there are so few who know how to decide on the size and screen of a half-tone that the engraver is forever receiving complaints about his work, when the cause of the complaint originated in the ignorance of the one ordering the half-tone. But what engraver would dare tell hospital people such a thing? He might have to be a patient there some day! It is well to be careful.

Some Mechanical Considerations

In ordering a half-tone give your measurement from left to right first and depth, or up and down, last. A half-tone two and one-half inches by four inches means that it must be two and one-half inches across the page and four inches the other way. It is well also to mark the size on the back of the photograph. The specifications should be clear. Thus: one half-tone, blocked, 120-line screen, line around, crop top and left side as marked, paint out figure at extreme left, retouch leg of chair, and silhouette down to three inches from bottom. Then go over all this personally with the engraver or his representative.

A half-tone indicates the kind of reproduction you desire, as distinguished from a line-plate, which is made from copy that consists of distinct lines or dots rather than paintings or photographs. The half-tone is made through a "screen," the number of dots per inch determining the screen. Newspapers use 65-line or 85-line, because of the coarseness of the paper. Better paper takes a finer screen. The screens most used are 120-line, 133-line and 150-line. The paper to be used should be selected before the screen of a half-tone is selected. Give the engraver a sample of the paper and let him advise you in the matter of screen. "Line around" means the little border line. If this is not wanted, say so. "Crop" means to use only so much of the picture as is marked for use. Thus a picture six inches wide might give better results if only five inches of it are used. There is no need to mutilate the picture. The engraver attends to the cut-off in his negative. Many things not wanted in a picture can be "painted out" on the original photograph, so that they do not appear in the half-tone. Many wonderful things can be done to remove defects by "retouching." A vest can be put on a man who failed to have one on when the picture was taken. Dresses can be lengthened. Flare-ups caused by the wind can be remedied. To "silhouette" is to make an outline by painting out such of the background as gives too solid an effect.

Some confusion is caused in ordering half-tones because few realize that when a picture is

reduced in size the reduction is not the same both ways. In order to know just what proportions you will get use the following directions: Turn the picture over and draw a line diagonally from the lower left hand corner to the upper right hand corner. If the photograph is ten by eight inches, that is, ten inches across and eight inches up and down, and you want a half-tone from it that will be five inches across, simply measure five inches from the left hand side, top and bottom. Draw a line from these marks right through the diagonal line. Then measure from the bottom of the line to where it cuts the diagonal and you will get what the other dimension will be. Be sure to make your marks very lightly with a soft lead pencil on the back of the picture. It is very easy for a picture to be ruined by bearing too heavily.

Drawings and Lettering

Sometimes better results can be secured by the use of a drawing. The imagination has a chance here. And often a picture thus can be secured which cannot be photographed. Sometimes a photograph can be used as the base for the drawing. Any magazine will offer abundant illustrations of the uses made of the drawing, the photograph and the two in combination. But if drawings are to be used, give the artist a little freedom in his execution. Tell him as clearly as possible what you have in mind. Make a rough sketch of it if you can. Then let his artist mind go to work on it, for if he makes the drawing exactly as you tell him the chances are the results will be grotesque. This happens because most people cannot "tell" another person about a picture with all the symmetry and detail which it has in the mind of the teller.

Let Your Pictures Work

Frequently a hospital will have a fine set of pictures taken and file them away "to use sometime." Let your pictures work as fast as you take them. Be on the watch for opportunities for their use. Inform your newspapers when you take new ones. Send them a set to look over. Pictures on an editor's desk are more likely to be used than those a few blocks away, or those about which you have phoned him. Revise your printed matter from time to time and use the new pictures as well as new text. To see the same pictures in an annual report from year to year after interest has been created is discouraging.

Use Some Enlargements

By having some striking pictures enlarged and framed, there is often an opportunity to hang them in the public school, the public library and other advantageous places. Where this is done

the pictures speak daily of the work the hospital is doing for the community. And those seeing the pictures constantly come to have the hospital in their mind as a part of their habitual thinking. Lantern slides can also be made from the negatives. These can be worked up into lecture form so that organizations and churches may keep them constantly in use. A typewritten lecture should go with the slides, or else type slides should be made which tell the story themselves.

When once a hospital develops the habit for pictures, each day will bring fresh opportunity for new ventures. These new suggestions should be studied in the light of the pictures already in hand. But no real chance to get a good picture story should be let go unused. It will not be long before many will be on the watch for your next photographic display. Keep everlastingly at it. Take only the best of your suggested pictures. And once you have the negatives, keep black and white glossy prints on hand so that every emergency may be met when it arrives.

The day for pictures for hospital publicity has already arrived. Use its opportunities to the limit while pictures are the thing!

TEMPLE UNIVERSITY OFFERS SUMMER COURSE IN HOSPITAL MANAGEMENT

A special course in hospital and institutional management will be given during the summer session of Temple University, Philadelphia, Pa., July 7 to August 15. The course was offered for the first time during the winter term of 1923-24 and will be repeated for the benefit of those who desire to take summer work. The course is designed to meet the problems which have arisen from the growth of the hospital into a complicated and difficult business undertaking and which call for trained executives and administrators.

The course is divided into two parts, the medical and the administrative. The medical division includes such subjects as medical nomenclature, hospital histories and chart records, laboratory records, relation of the social service department to the medical record room, and vital statistics. The lectures and instruction will be in charge of Dr. J. Norman Coombs, school of medicine, Temple University, and a member of the surgical staff of the Samaritan Hospital and the Garretson Hospital, Temple University. Other members of the faculty and of the hospital staffs will lecture on special subjects.

The administrative course will include such subjects as organization and administration, food conservation, storeroom equipment and supplies, engineering and construction, hospital records, the training school for nurses, the out-patient department, laundry operation and management, central linen room versus ward linen room, the personal equation, and the functions of the social service department.

Lectures and instruction in administrative work are in charge of Mr. Charles S. Pitcher, superintendent, Presbyterian Hospital, Philadelphia, whose practical experience

as storekeeper, resident steward, steward, deputy treasurer, and superintendent has fitted him for this position. Other lecturers will be Mr. John Smith, superintendent, Hahnemann Hospital, Philadelphia, who will devote four hours to hospital records; Miss Mary C. Eden, R.N., director of nursing, Presbyterian Hospital, Philadelphia, who will lecture on the training school for nurses; Dr. George E. Richardson, director, out-patient department, Presbyterian Hospital, who will lecture on the out-patient department; Mr. M. P. Burlingame, manager, Wilson's Laundry, Bryn Mawr, Pa., who will lecture on laundry operation and management; Mr. John S. McConnell, superintendent, Samaritan Hospital, Philadelphia, who will lecture on the subject of the personal equation in hospital management; and Miss Sue Murphy, social service department, Hahnemann Hospital, Philadelphia, who will give three lectures on the functions of the social service department. The lecturer on the subject of central linen room versus ward linen rooms will be announced later.

Lectures on hospital and institutional management will be given every morning, excepting Saturday, from nine to ten o'clock. Other related courses will be offered by the school of commerce daily so that students who matriculate for this course may carry additional commercial courses.

Readers who desire more complete information concerning these courses may obtain detailed information from Mr. Milton F. Stauffer, dean of the school of commerce, Philadelphia University, Philadelphia.

WORK PROGRESSING ON 1924 YEAR BOOK

Work is progressing on the fifth edition of THE MODERN HOSPITAL Year Book which will be ready for distribution late this fall. The classified directory will be divided into the six natural divisions of purchasing which were used for the first time in the 1923 Year Book and received the unanimous endorsement of hospital superintendents. These divisions of purchasing facilitate in finding information about construction, materials, general furnishings, clinical and surgical requirements, laundry equipment and supplies, food service equipment, foods and beverages.

DINNER FOR ILLINOIS NURSES

A get-together dinner will be held for the Illinois nurses at the biennial convention to be held in Detroit, Mich., June 16-21, 1924. The dinner will be held at the Statler Hotel, Thursday, June 19, at 7 p. m. Tables will be planned for alumnae associations with a separate table for individual members of the different districts. All who wish to attend the convention are asked to send their names, including the names of their schools to Miss Ellen V. Robinson, 660 Rush Street, Chicago, Ill.

HOLDS SIXTEENTH ANNUAL COMMENCEMENT

The sixteenth annual commencement exercises of the Mounds School of Nursing conducted by the Northwestern Baptist Hospital Association in connection with Mounds Park Sanitarium, Midway Hospital and Merriman Park Hospital, St. Paul, Minn., was held Friday evening, May 16. Dr. Charles R. Ball, member of the faculty of the nursing school and the Rev. S. P. Shaw, Sioux Falls, S. D., were the speakers.

A MODERN HOSPITAL IN SPANISH HONDURAS

BY WILLIAM H. WALSH, M.D., HOSPITAL CONSULTANT, NEW YORK, N. Y.

SHORTLY after the death of Vicente D'Antoni, the local manager of Vaccaro Bros. and Company, the natives of Ceiba, Honduras, where many of the company's activities are located, started a fund to erect a memorial to a man who was beloved by all classes of the native population and who had, during his short lifetime, contributed more to the welfare of the native workman and to the progress of the whole country, than any foreign influence that had ever reached these shores. Even today, a number of years after his untimely death, one may find little native houses decorated with pieces of black cloth and, upon inquiry, it will be learned that these are tributes to Don Vicente.

The writer has witnessed the pathetic spectacle of the blind and the lame who were beneficiaries of his bounty during his lifetime, returning at periodical intervals to the company's office to learn "when Don Vicente will return." These poor people have never learned of his death and are dismissed with the necessary funds to sustain them until the next visit, and an expression of the hope that one day Don Vicente will come back to live in the beautiful new home that will forever bear his name.

How the Hospital Originated

Upon learning of the desire of the natives, the members of the firm, whose hearts were touched by this evidence of gratitude, held various consultations with the leaders of the movement. These resulted in a conference which decided to build a hospital at company expense for the care and treatment of the poor. The results of that conference form the substance of this article. Little did the members of the firm realize then, or now, the economic value of this project to their own business. They were actuated by a generous impulse to perpetuate in a useful way the memory of an able man, with no

thought of any possible benefits that might accrue to the company.

The hospital was planned and constructed under the supervision of Favrot & Livaudais, architects of New Orleans, La. The original structure was practically completed when the present director was engaged by the company. The style of architecture is Spanish, of the pavilion type and constructed of hollow tile and stucco, with a red Spanish tile roof. The floors throughout all halls and corridors are of terrazzo and marble and all bases are coved. There are white tile floors in the bath and toilet as well as in the operating and maternity suites, wash-up room, diet kitchen, sterilizing room and nursery. The

floors in private rooms, offices, and out-patient rooms are of pine, varnished, waxed and polished.

The hospital is ideally located at the foot of a high ridge of mountains, about one quarter mile from the beach of the Caribbean Sea, surrounded by high cocoanut and royal palm trees.

The climate is pleasant throughout the year, the temperature ranging from 65° F. in the early morning, to 84° at noon, then dropping toward evening to 70° during the cool season. In the warm season the temperature averages high, but there are always refreshing breezes, so that the heat is never oppressive. Flowers of beautiful hue, including roses, orchids, poinsettias and bougainville are always abundant, and tropical fruit, such as avocados, pineapples, papayas, grapefruit, oranges, mangoes, bananas are plentiful throughout the year.

Has Specially Constructed Ambulance

The site is reached by a wide boulevard and also by a spur from the company railroad upon which a specially constructed ambulance with a Ford engine will offer emergency service to the near-by towns contributing to the support of the hospital. It will also be available in the event of



Exterior, Vicente D'Antoni Memorial Hospital, Ceiba, Spanish Honduras.

an accident along the line and, for this purpose, a complete first aid outfit has been provided for the car.

The central or administration building has two floors, with a single floor south wing wherein is located the receiving ward, accident room, outpatient department, x-ray rooms, laboratory and dental clinic. On the first floor of the administration building there, in the center, is a large memorial hall with marble floors and inlaid mahogany trim. This hall is to be used for conducting lectures in first aid, home nursing, infant welfare, prenatal clinics, and domestic science. In case of an epidemic or other grave emergency this hall could be transformed into a ten-bed ward. On the east side, leading from the memorial hall are located a waiting room for visitors or guests, the director's office, office of chief nurse, and the general office; on the opposite side are located the library and board room, the dietitian's office and a suite of rooms and bath for the resident physician.

On the second floor, reached by staircase and electric elevator, there are accommodations for fifteen semi-private or post-operative patients, two spacious operating rooms, a wash-up room, doctor's dressing room, sterilizing room, delivery room, nursery, linen room, diet kitchen and two special suites for private patients.

Connected to the main building by a covered corridor is the west wing comprising two units of twenty-six beds each, the corridor dividing the wing into two equal divisions, with the nurses' duty station in the center. It is proposed to divide these wards by cubicles but for the present one side will be utilized for males, the other for females. Each ward is provided with adequate bathing and toilet facilities, diet kitchen, treatment, service, linen and isolation rooms. An electrical signal system, with one unit for two beds, communicates with a panel and pilot light in the nurses' duty room. The floors are concrete with a smooth finish and painted with a durable dark green cement paint. Wood fibre runners extend through the centers of the wards and all halls.

The east wing is to be an exact duplication of the west wing except that the cubicles will be

built in during construction. There will be more spacious accommodations for maternity and children when this wing is completed.

Joined to the south wing by a covered passage is located the kitchen, dining rooms for officers, employees, ambulant patients, storerooms and laundry. Close by these is a 20,000 gallon water tank, one hundred feet high, to which water is forced from the city water supply by an electrical pump.

In addition to the buildings already outlined, there is an isolation house of sufficient capacity to care for twelve patients in cubicles, also a house for the accommodation of male and female help. The autopsy house, or morgue, is located about 300 yards southeast of the main building. The staff house which will accommodate from

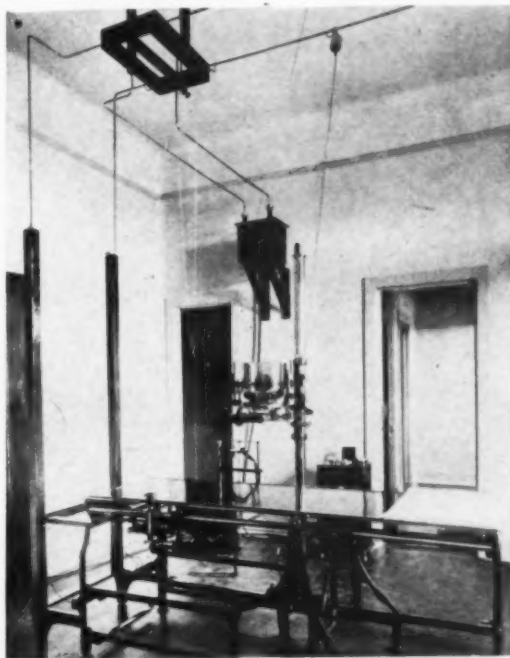
eight to twelve persons will be commenced in the near future, meanwhile the foreign staff will be housed in company cottages.

The hospital is managed by a director, appointed by the board of trustees, the majority of members being appointed by Vaccaro Bros. and Company and the remainder by the government. The first president is General Rius Rivera, a distinguished citizen who attained his military title during the Cuban insurrection.

The director is required to be a graduate from an accredited medical college, with special administrative qualifications. He is the supreme authority in the hos-

pital and every member of the staff and every employee of the institution must be nominated by him. There is a subdirector, the present incumbent being a native physician who was educated in Liverpool. In addition to his duties as assistant to the director, he is the admitting officer and the bacteriologist. A resident surgeon has complete charge of the surgical service and no doctor can perform an operation in the hospital until the resident surgeon certifies that he is competent. Native doctors who desire to specialize in surgery, are permitted to assist the resident surgeon for a probationary period, provided he is satisfied with their qualifications and aptitude.

There is also provision for a resident physician in charge of the medical service but it is planned to commence with the services of a



X-ray room showing combination radiograph and fluoroscope, and dressing rooms opening off this room.

visiting chief under the supervision of the director and subdirector. If this scheme does not work out satisfactorily the resident physician will be appointed. The statutes provide for a complete visiting staff and, as the institution develops, qualified local doctors will be appointed to the various services. If the financial condition of the hospital permits, these doctors will be paid a small honorarium for their work. Industrial cases, for which the hospital will receive payment, will be handled exclusively by the resident staff. When the hospital opens there will be a visiting staff for the following services: medical, obstetrical, dental, pediatric, eye, ear, nose and throat.

An interesting and somewhat unusual feature of staff organization, is the provision for an honorary staff upon which any distinguished physician or surgeon recommended by the director, may be appointed. The first appointees will be the teaching staff of the National Medical School, the representatives of the Rockefeller Foundation in Honduras, the director of the National Health Department, and certain foreign physicians and surgeons resident in the United States and Europe, who have consented to hold clinics at the new hospital from time to time.

The representatives of the Rockefeller Foundation will set up and inaugurate the laboratory which will be under the immediate charge of the subdirector, assisted by an American scientific assistant and a native technician who is a graduate nurse from an American hospital and who has had special training in one of the United Fruit Company's hospitals. The laboratory will offer its services to all doctors in the town of Ceiba and the department of Atlantida, as well as instruction to medical students and such doctors as desire to perfect their knowledge of technical procedures.

The nursing staff will consist of a chief nurse in charge of that department, a specially trained surgical nurse, a maternity nurse and a nurse for general duty, Americans or foreigners. In addition to this trained force there will be six nurse aids, selected from the better class of young native women with the object of preparing them for regular courses of nursing in American or

foreign hospitals. The general cleaning in the wards will be done by the necessary number of ward maids and orderlies.

A competent dietitian will be in charge of the procurement, storage, preparation, and service of food and, in addition to these duties, will conduct classes in domestic science for young girls and women.

The pharmacy will be in charge of a native pharmacist, graduate of an American college. In addition to his duties in the pharmacy, he will assist in dispensary work and in any procedure in the hospital requiring the services of a male nurse.

One of the greatest activities of the institution will be an out-patient department. The subdirector will be in charge and all of the staff in the hospital will assist in this department. The government has arranged to conduct an intensive campaign against uncinariasis and malaria throughout Honduras under the auspices of the Rockefeller Foundation, working in conjunction with the national health department. The Vicente D'Antoni Hospital has been selected as the headquarters in the department of Atlantida

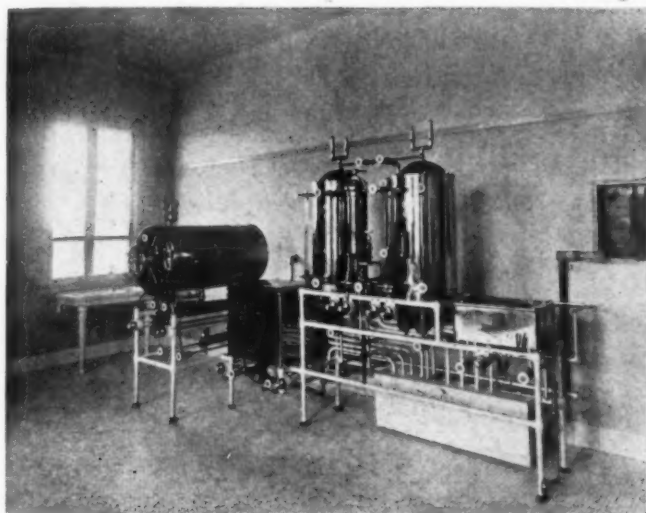
(of which Ceiba is the capital) for this work, and the campaign will commence coincidentally with the opening of the hospital.

Oral Examinations for All Patients

The dental work will be under the supervision of a native visiting dental surgeon, a graduate of one of our best American dental colleges. A trained prophylactic aid will be on duty continuously and every patient admitted will have a complete oral examination and the necessary prophylactic treatment. Emergency dental work only will be done in the hospital, but upon discharge each patient needing remedial work will be urged to visit his local dentist with a copy of the examination card. Should developments indicate the need for a resident dentist, one will be engaged, but it is the desire of the management not to provide services in the hospital which are already available in the locality. We believe the local dentists will respond willingly when called upon to treat those who cannot afford to pay.



Memorial hall to be utilized for prenatal and baby clinics.



Sterilizing equipment of the hospital.

The entire equipment of the hospital was bought through the purchasing department of Vaccaro Bros. and Company, upon the recommendation of the director of the hospital who received much valuable assistance from the service department of THE MODERN HOSPITAL. The total sum expended to date for supplies and equipment closely approximates \$60,000 and, in every instance, quality, serviceability and economy were stressed in the specifications. The furniture throughout is of metal, finished in mahogany color. This was selected because of its especial fitness for a tropical climate. The ward beds are finished in cream color, equipped with adjustable head and foot rests and irrigator rod attachments. Each private room is equipped with a metal cream colored day bed with cretonne colored mattress and pillows; a patient's bed, a bureau, chest of drawers, rocker, chair, bedside table, all metal and dark mahogany finish. A portable lamp with shade, and wood fibre rug of neat design complete the furnishings. Nurses' rooms are likewise furnished except that dressing tables and chairs are added.

Special care was taken in the equipment of the laboratory since it is hoped that it will become a center for study and research in tropical diseases. The equipment is adequate for clinical and microscopical diagnosis, bacteriological and serological examinations, pathological, histological and physiological chemistry. All appliances are electrical, as no gas is available here.

The operating rooms are completely equipped, one for general work and the other for the various specialties. An accident and receiving ward is equipped for surgical procedures in the outpatient department. In each ward there is also a surgical dressing room; connected with the operating suite there is a separate room equipped

for maternity work and across the hall from this room is located the nursery with the usual nursery equipment and with accommodations for six infants in bassinets.

The temporary main kitchen has been adequately equipped to meet immediate needs. The diet kitchens are provided with electric stoves, refrigerators, and all other equipment necessary in the preparation of special diets.

In equipping the x-ray department it was thought best to start with a small unit, and a stabilized fluoroscopic and radiographic unit was selected. This unit has a wide range of service and because of its simplicity of operation is particularly adaptable to our present needs.

All of the clinical and administrative blanks for the hospital were selected from those elaborated by the American College of Surgeons and The American Hospital Association, and the accounting system will correspond, in every particular, to those of American hospitals. A spacious record room is provided for the storage and study of clinical records.

Income and Endowment

When the company decided to construct and equip the hospital and dedicate it to the service of the country, it was agreed that the government would divert certain revenues to its support. A part of these funds commenced to accumulate when construction was begun so that when the hospital opened February 1, 1924, there was an endowment of about \$50,000, the greater part of which will be invested in bonds or first mortgages. The revenues allotted for maintenance will amount to about \$3,000 per month and this sum will be augmented by income from the laboratory, x-ray, private patients, donations, etc. It is also proposed by the management of the hos-



One of the operating rooms. An exact duplicate of this room is located on the other side of the central wash-up room.

pital to offer the services of the institution to the native employees of Vaccaro Bros. and Company who are now receiving medical service from the company hospital, and to include the immediate members of their families. When this step is accomplished the industrial welfare plans hereafter touched upon will be developed.

The town of Ceiba was a small hamlet, and the Department of Atlantida had not yet come into existence when the firm of Vaccaro Bros. and Company landed there about nineteen years ago; it can be readily understood, therefore, that the thriving city of today with a modern electric light plant, water and sewer system, paved streets and quaint Spanish houses, came into existence as a result of the industrial activities commenced by the far-sighted members of the firm.

While the development of this section of the country was largely due to the successful cultivation and exportation of bananas, the company has meanwhile built up a fleet of steamships, an ice and cold storage plant, sugar refining and power plants, distillery, brewery, slaughter house and various minor industries. The company operates 300 miles of railroad, and finally, controls a prosperous bank with branches throughout the country. No mention will be made of the varied activities of the firm in New Orleans and other sections of the United States, Central America and Mexico, but it is safe to predict that it will not be long before the plans adopted for the welfare of the people in Honduras will be inaugurated throughout the sphere of the company's influence.

The community, then, comprises the inhabitants of the city of Ceiba consisting of about 12,000 men, women and children, all more or less dependent upon the various Vaccaro industries for their livelihoods. It also includes all of the



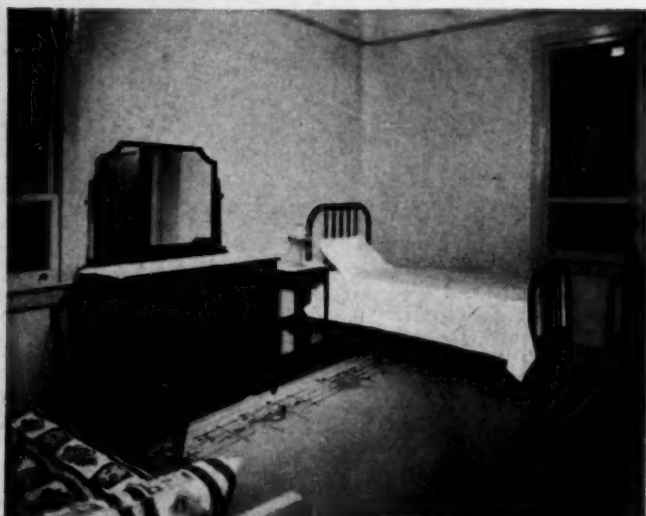
One of the wards showing signal system showing wood fibre washable runners on windows which are completely screened.

towns along the railroad, the extensive farms connected thereto, and a wide expanse of cultivated lands now easy of access only by mules. The total population may be conservatively estimated at about 70,000.

Center for Community Health Work

The principal diseases most common in this country are uncinariasis and malaria. Investigations recently made by the Rockefeller Foundation, show that hookworm disease alone reaches the amazing height of 70 per cent. Our own preliminary investigations indicate the incidence of malaria as closely approximately 60 per cent. With these facts as a basis upon which to guide us, our first efforts will be directed against uncinariasis, and this work will be conducted by the hospital in cooperation with, and under the supervision of, the Rockefeller Foundation. In combating hookworm disease it is essential not only to provide the laboratory equipment for diagnosis and the therapeutic agents for its cure, but to improve sanitary conditions so that recurrences and new cases shall not occur through soil pollution.

The hospital will be the headquarters for the diagnosis and cure of the disease and from the same place will be issued the directions to the special sanitary police for the conduct of the sanitary campaign. When a patient is examined for hookworm he will also be examined for malaria and any other suspected pathological conditions, so that each patient will be completely rehabilitated when his case is completed. The necessary treatment for these diseases in the out-patient department will be free of charge to all natives. Field laboratories will be established in the various towns, sanitary police will be sent coincidentally,



A typical private room showing complete metal furniture. Entrance to bath room adjoining can be seen in the mirror.

and the campaign will be continued until the entire population has become acquainted with the ghastly effects of these diseases, and the simplicity of their prevention, treatment and cure.

However great may be the good accomplished with those who come to the hospital, it is realized that permanent results cannot be effected in the community without a visiting nurse service, consequently this work will be commenced with one specially trained obstetrical nurse at Ceiba who will be placed at the service of the doctors for maternity work. For those who can pay, a small charge will be made but for the visitation of discharged patients the service will be free since it is desired to establish a complete follow-up service.

The visiting nurse will assist at the prenatal clinics at the hospital at which time each woman will be afforded the opportunity to have a complete examination. Weekly baby welfare clinics will also be an important feature of the hospital's activities and upon these occasions the dietitian will instruct the mothers on the principles of cooking.

Campaign Against Industrial Accidents

A campaign for the prevention of industrial accidents will be inaugurated by the formation of classes of foremen for the instruction of first aid. Inspection will be made at the machine shops, refineries, and other plants and suggestions made for the elimination of hazards, the improvement of working conditions and such sanitary measures as may be indicated.

Arrangements have been completed with the National Health Department for the instruction of the public in personal hygiene, and the prevention and treatment of venereal diseases. Close cooperation will be maintained with the local health officer and the laboratory will be at his disposal for the diagnosis or study of suspicious cases arriving at this port.

In the past it has been customary for patients arriving from adjoining towns to be hospitalized, regardless of whether or not they could be treated as out-patients. Very often these poor people require diet, care and rest more than medicines or surgical interference, but heretofore they have either occupied a bed that was urgently needed for a more serious case or were allowed to remain in the street without clothes, food or shelter. To meet this condition, the old hospital which becomes the property of the new institution, will be renovated and transformed into an out-patient annex and occupational clinic. All out-of-town ambulant patients will be treated at the hospital and then sent to the annex where they will live

until rehabilitated. The annex will be in charge of an expert American occupational therapist who will conduct occupational shop activities.

A concession is available for the manufacture of brooms and brushes and this activity will be commenced at an early date. Women will be taught weaving, basket work and art needle work, while men will be instructed in woodwork, metal work and other handicrafts. Thus the patient will receive the necessary medical and hygienic treatment and, in addition, will utilize his time in an occupation that will keep him out of mischief, improve his efficiency and productivity. We believe that under the able management of our occupational therapist the output of the shops, particularly the broom factory, will in time prove a source of considerable revenue.

In conclusion, it may be briefly stated that the Vicente D'Antoni Hospital is an institution organized and equipped to give the best modern treatment and care to the sick. It goes a step farther in formulating its plans to the end that it shall become an educational and welfare center for the propagation of useful information which will prevent the incidence of disease; increase the longevity and economic competence of the people and spread happiness and good will throughout the community.

HOW CORPORATION CONTRIBUTIONS ARE MANAGED BY MORTON HOSPITAL

The Morton Hospital, Taunton, Mass., has a system of management of funds contributed by corporations that has proved successful, according to Miss Ursula C. Noyes, superintendent. The corporations contribute at the yearly drive of the hospital. Contributions from firms range from \$50 to \$500 a year, the total in 1924 being \$4,150, representing twenty-three corporations. There are no arbitrary rules for the management of this fund, the dispensation being attended as the need arises.

The advantages of the fund plan are: (a) help of worthy working people by their employees, thus promoting mutual friendly feeling; (2) study by business men of the management and need of the institution to which they contribute; establishment of friendly relations and personal interest between the contributing corporation and the hospital; (4) a very material increase in the contribution toward the maintenance of the hospital. The workman's compensation takes care of all accident cases, but the fund helps patients who do not come under this ruling and are recommended by the corporation for which they are working. There are no arbitrary rules for the management of this fund, the dispensation being attended to as the need arises.

The proceeds from pageants held in the various cities of Virginia National Hospital Day, May 12, by the foundation fund committee of the Graduate Nurses' Association will go toward a \$50,000 fund which the association has pledged itself to raise for endowing a chair of nursing at the University of Virginia, Richmond.



The MODERN HOSPITAL

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Inc.

OTHO F. BALL, M.D., *President*
22 East Ontario Street Chicago, Ill.

JOSEPH J. WEBER, M.A., *Editor*

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MORE ABOUT THE OPPORTUNITIES OPEN TO THE A. H. A.

IN THE May issue some suggestions were presented regarding the benefits which may accrue to the hospital field from a strong central organization of hospitals operating for the common good. The subject was properly referred to as an economic question, and not a matter of mere sentiment. It may be helpful to review some of the economic considerations at this time when current figures are available from our annual survey, just completed.

Measured by total investment, annual operating expense, new capital invested annually, personnel employed and numbers of people served, it would appear that the hospital field represents not only one of the most active agencies working for better health, but also one of the large industries of the country.

Our survey of the field shows that at present there are in the United States 6,762 hospitals with 770,375 patients' beds. These totals do not include a considerable number of "medical boarding houses" which, though operating as hospitals, have inconsiderable capacities and facilities. Of allied institutions, including homes for children, aged, deaf, blind, and similar institutions, there are 1,901 with 245,260 bed capacity.

Closely associated with hospitals are the approximately 4,000 general and special dispensaries and clinics, which must be considered in connection with any general survey of the field.

In the course of a year almost ten million persons become resident hospital patients in this country and between seven and eight millions more are diagnosed and treated in dispensaries and clinics. Even allowing for discrepancies, such as the inclusion of a small percentage of dispensary cases in the hospital total, these figures cannot but be impressive as an indication of the number of persons served.

On the financial side, a conservative valuation of hospital property, including land, buildings and equipment, would place the total in excess of five billion dollars, while the annual operating expense of these institutions exceeds one billion dollars. New capital is being invested for the construction and equipment of new buildings at the rate of more than \$300,000,000 annually.

Do not these figures signify that the hospital field involves economic considerations of outstanding importance? Is it not the plain duty of those responsible for hospital service throughout the country seriously to consider ways and means whereby more research into methods of operation and organization can be carried on at the one expense for the benefit of all? Could there be a

more ideal field in which to develop a strong central organization, equipped to make useful investigations and services, conduct efficient studies of the various procedures of hospitals and dispensaries, watch proposed hospital and health legislation and, what is still more important, initiate constructive legislation and be fully prepared to give sound authoritative counsel on hospital and related problems? In short, should not the American Hospital Association seize this unparalleled opportunity now, and, in doing so, have the whole-souled backing of the entire hospital field?

WILL THE HOSPITAL FIELD COOPERATE?

SINCE writing the preceding editorial there has come to our desk an advance copy of a letter from the American Hospital Association addressed to the hospital field of the United States and Canada, announcing the organization of an institutional membership campaign. The purpose of this campaign is to bring every bona fide hospital in the United States and Canada into the American Hospital Association as an institutional member, as a basis for organizing all the hospitals "into a common protective and promotional service association for the hospitals as operating units for service to patients."

Reasonable progress has already been made in the installation of the underpinnings of this campaign. Districts have been defined, a number of district chairmen have already accepted appointment and are selecting their committees, suitable literature is being prepared and other necessary steps are being taken. It is expected that by the time of the annual conference of the association next October, the campaign will be well under way.

The American Hospital Association cannot go forward and serve the field as it should without the backing of the entire field. A campaign to win this backing is now under way and as it progresses should meet with a prompt and hearty response. The field needs a strong progressive service association. It can have it if every hospital will join the association as an institutional member.

NOT LESS SCIENCE BUT MORE SYMPATHY

THE past half century has witnessed not only a tremendous growth in the hospital field but also a vast improvement in the construction, equipment and organization of individual hospitals. We have, in many instances, substituted fire-resistive buildings for fire traps;

we have evolved floor plans that save the time and energy of the hospital nurse; we have equipped our hospitals with time-saving and strength-saving devices of the latest design; we have installed efficient record systems; provided adequate technical facilities and organized monthly staff meetings. We are beginning to place our nursing activities on a modern educational basis, we are organizing scientific dietary departments, introducing occupational therapy and installing departments of physiotherapy. But we have been so busy building, equipping and organizing our institutions under the incessant demand for increasing facilities that, in many instances, we have wholly neglected, and sometimes failed to give adequate emphasis to that most fundamental of all qualities — human sympathy.

In his article "On Humanizing the Hospital," Dr. S. S. Goldwater gives us a vigorous, yet withal kindly, discussion of this extremely important, though often neglected, phase of hospital life. He calls our attention to many of the dehumanizing phases of hospital life, comments sympathetically on ways and means that have been suggested or actually adopted by various hospitals to overcome them, and offers a number of sound suggestions for getting rid of the "institution" in order to preserve the hospital.

OPERATING ROOM DECORATION AND SURGICAL EFFICIENCY

IN visiting the operating rooms of recently built hospitals one is impressed by the fact that, with rare exceptions, the floors and wainscots of these rooms and, in some instances, the walls and ceilings are finished in colors rather than in white. In some cases various shades of green have been used, in others French gray; still others are in ivory.

This tendency is due to the fact that, with the increasing complexity of surgical intervention, special illumination, quite powerful and now almost wholly artificial, has become urgent. The amount of light thrown back to the operator from the white draperies, white floors, walls and ceilings is so great that it creates a pronounced eye fatigue, and interferes seriously with the surgeon's view of the field of action. Hitherto in the selection of colors for the operating room there has been no evidence that scientific consideration has been given to the exact color of the field of operation or that a scientifically proven complementary color has been secured. Recently, however, these colors have been scientifically determined by Dr. Paluel J. Flagg of New York (see page 555). On the basis of his findings, Dr.

Flagg contends that color fatigue is wholly eliminated by the use of a definite bluish green color, the true complementary color to the operating field, a color which permits of maximum illumination, and which, he contends, definitely disposes of the problem of reflection and color fatigue.

That the presence of white walls and draperies in the operating room results in a lower visual efficiency is no longer open to debate. The obvious thing to do, therefore, is to substitute a combination of colors which will not call for an undue degree of pupillary reaction and retinal adaptation and which, at the same time, will produce a pleasing effect psychologically.

Whether Dr. Flagg has hit upon the final solution of this important problem we are not prepared to say. It is well known that no two persons have exactly the same color perception and, as Dr. Nelson M. Black, the well-known ophthalmologist of Milwaukee, has pointed out, even in those whose color sense is practically identical there is frequently an ocular discomfort amounting almost to a phobia, produced by certain colors or combinations. Thus the color scheme that gives perfect comfort to one may prove annoying and distasteful to another.

Dr. Flagg's paper is extremely interesting. It should lead to further experimentation and discussion which will either confirm his findings or eventually result in some practical scheme of decorating and furnishing operating rooms which will give a maximum amount of ease and comfort to the eyes of the surgeon.

AN ADVANCE IN NURSING EDUCATION

THE first annual catalogue of Western Reserve University's school of nursing, which was established in June, 1923, contains an interesting announcement of the merging of the schools of nursing of Lakeside Hospital, Cleveland Maternity Hospital, and the Babies' Dispensary and Hospital of Cleveland with the university's school. As a result of this merger, Lakeside Hospital becomes the medical and surgical department of the university's school of nursing, Cleveland Maternity Hospital, its obstetrical department and the Babies' Dispensary and Hospital, its pediatric department. This leaves the students of the university's school of nursing to secure their experience in the care of communicable diseases and mental and nervous cases in the new pavilions of the Cleveland City Hospital with which an affiliation has been arranged.

These mergers, as a result of which the various individual schools will sink their identity in the larger university school, give concrete expression to an idealism and self-sacrifice of an exceed-

ingly high order. This is true of all three schools but especially so of Lakeside which began its career twenty-six years ago, and which has always stood for progress in nursing education.

With these acquisitions the school of nursing of Western Reserve University bids fair to be one of our strongest and most progressive schools.

BROADENING THE HORIZON OF NATIONAL HOSPITAL DAY

ON ANOTHER page we publish a resolution adopted at the last meeting of the board of trustees of the American Hospital Association under which the association, beginning with May 13, takes over National Hospital Day and assumes responsibility for the activities of the National Hospital Day committee.

This action is most commendable. National Hospital Day should never have been controlled and capitalized by private interests. That very fact was bound to limit the scope of its interest and warp its larger and legitimate purpose.

The American Hospital Association now has an opportunity, such as it has never had, to acquaint the whole public with the purposes of the hospital and bring about a better interrelationship of hospital and community.

At this point, the association may well ask itself whether, in the celebration of National Hospital Day, it is the part of wisdom to "go it alone" or open negotiations for the purpose of joining forces with the great national health and hospital agencies represented in the National Health Council and the American Conference on Hospital Service, with a view to inaugurating a National Health Week during which hospitals and their activities would receive appropriate recognition.

SHARPEN YOUR AX

THERE is an old story of the man who was too busy chopping wood to have time to sharpen his ax, a story that surely carries a helpful suggestion for all of us who are working in the hospital field.

Does this apply to you in the administration of your hospital, and does it apply to any of the heads of your departments? Just as the ax blade is sharpened through contact with the grindstone, so there is a keen edge put on our thought processing by friction with the ideas of others.

The superintendent or other hospital executive who is too busy chopping wood to sharpen his ax, too busy with the details of doing work in the same old way to absorb and benefit from the ideas of others—is missing a stimulus which is essential to personal progress and a well-rounded service to his institution.

The Modern Hospital Publishing Co., Inc., announces a prize essay competition on the vitally important subject:

THE INTERRELATIONSHIPS OF HOSPITAL AND COMMUNITY

The purpose of this competition is to concentrate the thought of hospital, public health, medical and social welfare workers on this timely subject for the purpose of crystallizing opinions and defining future objectives.

Cash Prizes as Follows Will Be Awarded

First Prize - - \$350

Second Prize - - \$150

Third Prize - - \$100

There will also be such honorable mentions as may be authorized by the Committee of Awards.

The general program of the competition will be published in full in the July issues of The Modern Hospital and The Nation's Health.

The Modern Hospital Publishing Co., Inc.
22 East Ontario Street, Chicago

WHAT GENERAL CUSTOMS GOVERN THE VACATIONS OF HOSPITAL EMPLOYEES ?

THE APPROACH of summer brings the problem of vacations to the consideration of hospitals as well as other organizations. The adjustment of the vacations of the various personnel of the hospital presents difficulties from the very nature of the institution and its services. The questions of when the particular employee shall have his vacation, both with respect to the length of service and the time of the year, and how long the vacation shall be, are matters which call for the careful planning of hospital officials. Since customs in regard to the vacations of employees differ in various institutions it is of interest to know the policies of a few hospitals in regard to the matter. Accordingly, we have selected, at random, the policies of several well-known hospitals in different parts of the country to illustrate what is being done along this line.

At the Brooklyn Hospital, Brooklyn, N. Y., vacations are taken between May 15 and October 15. Employees are given full time vacation after one year's service. Half the vacation may be taken after six months' service. The length of vacations is as follows: heads of departments, four weeks; and clerical staff, two weeks.

The Presbyterian Hospital, Philadelphia, Pa., grants its employees a vacation at the end of a year's service. At the end of a year, in case that an entire year's service has not been completed, the hospital often gives the regular allotted vacation. In cases where employees leave the service after a vacation, the time for which has not been fully completed, this time is deducted from their pay. In the training school the following terms are given: staff nurses, one month; training school nurses, three weeks; dietitian, one month; anesthetists, one month, and orderlies, two weeks.

Among the clerical force one month is given after five years' service; three weeks after four or three years' service, two weeks after two years' service and ten days at the end of one year. The night telephone operator is allowed a week. In the housekeeping department the housekeeper and assistants have one month. All other employees receive one week after a year's continuous service. After two years' service they receive two weeks with pay. In the engineering department the chief engineer is allowed one month with pay. This period is split up into several periods, as it is not advisable for him to be absent for so long a period. Assistant engineers are given three weeks, firemen two weeks, and regular mechanics on the monthly pay roll, two weeks.

Vacation rules at Mount Sinai Hospital, Cleveland, Ohio, specify that under no conditions is a vacation to be given until after a year of service. If the incidence of

employment is such that the individual cannot take vacations during the regular vacation period during the months of June, July and August, he or she is obliged to wait until the following vacation period. The house orders explain that the purpose of a vacation is to fit an individual for the continuation of activities of the position and that, for this reason, vacations at the end of a specified period of time have been discontinued.

In the administrative department three weeks is the maximum of vacation time, and this period is given to the accountant, cashier, registrar, telephone operators A and B, secretary, statistician. Two weeks are given the assistant registrar, telephone operators C and D, stenographers and billing machine operators. One week is given to the page.

In the housekeeping department a month is given to the matron, three weeks to the assistant matron, two

weeks to the sewing women, one week to the cleaning women and porters after a year's service, and ten days to cleaning women and porters after two years' service. Head laundrymen are given two weeks, laundry helpers, one week after one year's service and ten days for longer service than a year. In the mechanical department the chief engineer is given one month, the engineers and firemen, two weeks after one year; for two years and over, three weeks; maintenance man and chauffeur, two weeks; elevator man, one week; carpenter, none. In the dietary department one month is given to the dietitian and assistants, two weeks to the

cooks, one week to the other dietary help after a year's service; ten days for service longer than one year. In the commissary department the storekeeper is given two weeks and the storeroom clerk two weeks.

In the professional group, resident doctors are given two weeks; interns, ten days; and pharmacist, two weeks. In the nursing department the principal and assistants, as well as head and pupil nurses, are given one month, assistant head nurses, three weeks; secretary, two weeks; and graduate nurses; two weeks. Ward attendants and orderlies are given one week after a year's service, and two weeks at the end of two years' service. In the laboratory and remaining departments the arrangement is as follows: chief, one month; technicians, two weeks; chief anesthetists, one month; and assistants, three weeks. The chief worker in the out-patient service receives three weeks; social workers, three weeks; registrar and stenographer, two weeks; physiotherapists, two weeks; and part-time physiotherapists, one week.

The Hartford Hospital, Hartford, Conn., definitely schedules employees' vacations in order to eliminate the inconvenience of the absence of certain employees at the

Although there are certain general principles which govern the vacations granted to hospital employees, we find that the regulations of various hospitals differ according to the established custom of the individual institution.

It is understood that vacations imply a specified period off duty during which time the employee's salary is continued the same as during a similar period of work, though in some hospitals, clerks and a few minor employees are given vacation periods without pay.

In general, hospitals grant a vacation at the end of a year's service, though this rule varies somewhat in different institutions. From three weeks to a month's vacation is generally given to administrators and heads of departments, while a two weeks' period appears to be the standard period for other employees in the majority of hospitals which were taken as representative.

same time. This also gives preference in the selection of dates to those who have been longest in the service. Employees are not given a vacation until after a year's service after which they are given two weeks with pay. This ruling applies to all employees except the general superintendent, the superintendent of nurses, and her assistants and head nurses, all of whom are given a month's vacation.

Wesley Memorial Hospital, Chicago, Ill., offers a month's vacation to heads of departments and graduate nurses, and four weeks to student nurses. Employees of the kitchen, dining room and those of the housekeeping department receive one week's vacation after one year, two weeks, after two years, and three weeks after three years. The telephone operators and minor clerks in the office receive three weeks.

Michael Reese Hospital, Chicago, Ill., grants a two weeks' vacation to all its employees who have been in service for a year. Nurses and social workers are entitled to a month's vacation and department heads, three weeks. Vacations may be taken at any time, if they do not interfere with the hospital work and if it is agreeable to department heads. There is no increased vacation period for length of service.

At Touro Infirmary, New Orleans, La., the vacation period extends from May 1 to October 1. Only those employees who are on the payroll in January are eligible for vacation for the first year, although a proportionate part of the vacation period is allowed when a full year has not elapsed. The period allowed for vacation is three weeks which period is increased for those whose work involves longer hours and continued application, as is the case with supervisors of the nursing department, while a shorter period is given to the orderlies, housecleaning personnel and others of the class whose work involves manual labor.

Baylor Hospital, Dallas, Texas, provides one month's vacation to professional employees, as a general rule. Clerical and other employees are given two weeks. Vacations are given after a year's service excluding the vacation period, and vacations may be taken at any time of the year.

The Tacoma General Hospital, Tacoma, Wash., provides for a month's vacation to the faculty and graduate nurses, two weeks to the student body and other employees. The first vacation is given only after a year's service. The following years' vacation periods are arranged in the interests of the employee and the hospital.

AN APPRECIATION OF DR. C. IRVING FISHER

BY CHARLES F. YOUNG, SUPERINTENDENT, SYRACUSE UNIVERSITY HOSPITAL, SYRACUSE, N. Y.

Dr. C. Irving Fisher, who for the past forty years was one of the best known of hospital executives throughout the country, passed away at his home in Lockport, N. Y., April 26, 1924. His busy, useful life will long be remembered by those who knew him as a co-worker, teacher or friend. A brief review of his life and activities is of interest to the hospital world.

Dr. Fisher was born at Canton, Mass., April 25, 1847. Both his father Cyrus Fisher, and his mother, Caroline Guild, were descended of early New Englanders who came to America shortly after the voyage of the Mayflower. His parents were life-long residents of Canton where the son spent his early life and there received his early education in the public schools of Canton.

During his early life he received excellent mechanical training in the shop of his father who was a machinist and inventor and who made many of the cannons used in the Civil War. This early training served Dr. Fisher to advantage in later life when his opinions on mechanical equipment of hospitals were much sought after and respected.

He attended the Bridgewater Normal School and was later graduated from the Harvard Medical School in the class of 1870. At times during his school and college life he taught in the public school of Provincetown where he is still remembered as a schoolmaster. From 1872 to 1875 he was a physician to the Port of Boston when the row boat and the sail were the accepted modes of transportation to and from his Deer Island quarters and the mainland.

In 1875 he began private practice and was general practicing physician in Brookline and in Holbrook, Mass., until 1883 when he accepted the superintendency of the Massachusetts State Infirmary at Tewksbury, Mass. It was here that the late Dr. Herbert B. Howard and Dr. John R. Nichols were his interns and later, his assistants. He always spoke of them as "his boys" and felt great satisfaction and pride in their subsequent success in the hospital field.

He took charge of the infirmary at Tewksbury directly

after the famous investigation when General Butler was overthrown, and his success as an administrator was so marked that the managers of the Presbyterion Hospital in New York City called him to the superintendency of that institution in 1891. From that date until his retirement in 1914, his work and influence helped greatly in building up the hospital and placing it in the front rank of hospitals of the country.

Soon after his retirement he was made a member of the board of managers of that hospital and held that position the remainder of his life. He was also a member of the board of governors of the New York Skin and Cancer Hospital of New York City, and a senior elder of the Madison Avenue Presbyterian Church.

In 1875 Dr. Fisher married Clara F. Leonard of Bridgewater, Mass., who died in 1911. In 1918 he married Miss Margaret Bewley of Lockport, N. Y., a graduate of the Presbyterian Hospital school of nursing and a well-known pioneer in visiting nurse work and social service organization.

Mrs. Fisher, a son and two daughters by the first marriage, survive Dr. Fisher.

His son, Irving L. Fisher, is district manager, New England Telephone Co., Bangor, Me. His daughters are Mrs. Warren Wright, wife of the professor of Latin, Smith College, Northampton, Mass., and Mrs. William S. McCann, Baltimore. Mrs. McCann is herself a graduate in medicine as well as her husband who has been appointed professor of medicine at the new Eastman Medical School soon to be opened at Rochester, N. Y.

After his retirement, Dr. Fisher spent a great deal of his time at his beautiful home in Lockport where he busied himself in gardening, and other active work. He also spent some time in traveling in Europe, in the Near East, Egypt and the West Indies. Dr. Fisher was active until the last and died, as he had often expressed the wish, peacefully, without warning and without long illness.

To the many who experienced the inspiration of his friendship the memory of Dr. Fisher's loyalty, honesty and faithfulness will be an influence for better work.

RECENT HOSPITAL DECISIONS

BY DOROTHY KETCHAM, ANN ARBOR, MICH.

**Statutes
Regulating
Physician's
Testimony**

The physician testifying as witness at common law formerly had no right to refuse to disclose information communicated to him in his professional capacity; nor could the patient exclude such information, that is, there was no privileged communication between physician and patient. The results of such a situation were so undesirable that statutes have, from time to time, been enacted in practically every jurisdiction which made the communication between physician and patient privileged from compulsory disclosure in the courts of law. These statutes are designed to inspire confidence and to protect both parties. It is impossible to go into the details of such situations which have arisen as a result. But it suffices that in general a physician cannot be required or permitted to give evidence in court as to information acquired by him in his professional capacity. (28 R.C.L. 122.) He may not be able to testify even after the patient has died. The method of introducing the material is unimportant. Thus "it is the consensus of judicial opinion that the records of a hospital or asylum when offered in evidence against a patient or privy in interest are inadmissible, being within statutes making a physician incompetent to testify regarding matters of which he acquires knowledge while acting in his professional capacity. The introduction of the records would obviously be an evasion of such statutes; for though the physician would not actually testify, yet the privileged matter sought to be barred would be effectually placed in evidence." (28 R.C.L. 123.) The fact that a municipal ordinance has required the hospital to keep such a record, is no reason for the violation of this statute. (208 Mo. 162; 105 SW 709.)

Some time ago Massachusetts required that hospitals supported by the state or town or offering public charitable treatment, are "to keep records of the cases under their care, and the history of the same, in books kept for the purpose." These books are to be admissible in court "as to all matters therein contained." (Stats. 1905 C 330.)

A more recent provision in the same state reads "Hospitals supported in whole or in part by contributions from the commonwealth or from any town, incorporated hospitals offering treatment to patients free of charge, and incorporated hospitals conducted as public charities shall keep records of the treatment of the cases under their care and the medical history of the same . . .". An amendment provides that these records kept by hospitals shall not be open for public inspection as required by Ch. 66 sec. 10 C.L. The amendment reads "Section 10 of Chapter 66 shall not apply to such records provided that upon proper judicial order, whether in connection with pending judicial proceedings or otherwise, or upon order of the head of the state department having supervision of such hospital, (the department of public welfare) and in compliance with the terms of said order, such records may be inspected and copies furnished on the payment of a reasonable fee. (Acts 1923 Ch 337.) The records of venereal diseases, it is elsewhere declared, are not to be public records. (G L 1921 Ch 111 Sec. 119, 120.)

It is not unusual that statutes in the various states require reports and records of the various hospitals as in cases of birth or death, contagious disease, venereal

disorders, etc. Arizona states that lying-in institutions, hospitals, almshouses or other institutions, public or private "to which persons resort for treatment of disease, confinement, or are committed by process of law, are hereby required to make a record of all personal and statistical particulars relative to the inmates in their institutions—." (1913 Civil Code sec. 4421.)

A similar requirement is made in Colorado, Florida, Idaho, Illinois, Louisiana, Maryland, Michigan, and others.

As Wigmore has pointed out, so far as the hospital itself is concerned, the record is relied upon in affairs of life and death (Wigmore on Evidence 2d ed. vol. 3 sec. 1707) and to call the physicians and nurses to the witness stand to testify referring to the records "to refresh their memory" seems somewhat futile as to the details of hospital cases. However, this practice has been ratified in some jurisdictions.

Some states have made the hospital records admissible in evidence particularly in the case of workmen's compensation laws. Minnesota states that the records kept by a hospital may be admissible as evidence of the medical or surgical matters stated therein, "but shall not be conclusive proof of such matters." (Sts. 1921 ch 41 sec. 54.)

Missouri has declared that the records of "every hospital or other person furnishing the employee with medical aid "is admissible by certified copy." (Rev. St. 1919 sec. 13605.) Pennsylvania declares that "the records kept by a hospital of the medical or surgical treatment given to an employee in such hospital shall be admissible as evidence of the medical and surgical matters stated therein." (Sts. 1919 June 26 sec. 6, Digest sec. 22044.)

Massachusetts has provided that copies of hospital records which are certified by the persons in charge, to be true and complete, shall be admissible in evidence in proceedings before the industrial accident board or any member thereof. The board may also require the original record. (G A 1919 ch 198 p 152, sec. 19.)

New York on matters of *habeas corpus* in insanity proceedings makes admissible the patient's "medical history—as it appears in the case book" of a state hospital (Consol. L. 1909 Insanity sec. 93.) Another provision permits mentally defective persons committed to custody to apply for *habeas corpus* and adds "the history of the patient as it appears in the case records shall be given in evidence." (Sts. 1919 ch 633 or Consol L. 1909, Ch. 71, sec. 35.)

It is unquestionably true that in many jurisdictions and under varying circumstances reliable hospital records have been and are excluded from use. There are certain types of information contained therein, however, not medical knowledge and not necessary to diagnosis and prescription which may be required. Thus before information is excluded as a privileged communication it must appear that the physician acquired the same in his professional capacity. Information as to the date on which injuries were inflicted, or the manner in which they are received are not ordinarily necessary for treatment. The identifying information may not be considered privileged, as was shown in the case of (*Garrett vs. City of Butte* 221 Pac 535) quoted elsewhere in this issue.

There are really three types of cases in which, for

the most part, hospital records are desired: to show the condition of an applicant for insurance, the extent of injuries of a person claiming damages, and actions under compensation laws. The records have been repeatedly excluded under the two former situations, but specific statutes have permitted the introduction of the records in workmen's compensation cases.

One of the questions which faces every hospital is how far can information be given out to reputable agencies, hospitals, physicians, and others concerning the condition and care of the patient. The consent of the patient to such release would be a reasonable but not always possible precaution. It would seem that such exchange of data would be a professional courtesy governed by the code of ethics rather than by strict conformity to the lettered requirement. Identifying data not bearing directly upon the matter of diagnosis and treatment can be released, but strictly medical and professional data

under our present system must be jealously secreted apparently. In comparatively few instances is the information secured by the institution or the physician strictly confidential, but, as the court points out, "In order to invoke the rule of exclusion, there are two things which must appear: (1) That the relation of physician and patient existed at the time the statements were made; and (2) that the information given the physician was 'necessary to enable him to prescribe or act for the patient.' In view of the language employed, it would not seem that—statements made by a patient to his physician concerning his place of residence, his place of birth, the names of his parents, whether he is married or single, the place where injured, the means of his conveyance to the hospital for treatment, or the like, constituted information necessary to enable the physician to prescribe for the patient." (*Garrett vs. City of Butte*, 221 Pac 535.)

SALARIES PAID HOSPITAL OFFICIALS*

By J. W. MEYER, MANAGER, AURORA HOSPITAL, AURORA, ILL.

SOME time ago I was asked to open a discussion on the topic "Salaries Paid Hospital Officials and Employees," and to limit my remarks to a very few minutes. This subject is one of vital interest to a hospital organization and its management, as this item usually amounts from 40 to 55 per cent of the total expense. In order that I might present a general view of the salaries for different positions generally found in hospitals, I

tober, 1921, p. 347, and September, 1922, p. 208.

In the replies for superintendent of nurses, there was one position from Chicago which combined this position with that of hospital superintendent. In this group also these two positions were combined in a number of the replies from the remainder of the state. It will be noted that the returns for interns were small, indicating that most of the hospitals of the state do not have interns.

Position	SALARY PER MONTH					
	Chicago Hospitals			Other Hospitals of Illinois		
	Number of Institutions	Range	Average	Number of Institutions	Range	Average
Superintendent of nurses.....	17	\$125-400	\$184	20	\$125-250	\$165
Assistant superintendent of nurses.....	13	100-200	132	17	95-140	116
Interns.....	14	0-75	...	1	125-175	...
Night supervisor or superintendent.....	17	80-150	110	22	75-115	96
Surgical supervisors.....	15	100-175	128	19	90-125	112
Floor supervisor.....	12	80-125	107	18	75-115	91
Anesthetist.....	12	100-140	120	4	90-140	110
Laboratory technician.....	16	85-250	125	17	75-200	118
Graduate nurse general floor duty.....	19	85-125	110	10	80-110	88
Engineer (with room and board).....	9	90-264	165	20	60-250	107
Engineer (without room and board).....	9	125-275	192	4	170-235	201
Janitor.....	16	50-145	75	20	40-115	64
Cooks.....	20	65-205	111	21	55-200	77
Dining room help.....	18	30-65	49	22	25-60	42
Nurse attendants.....	18	35-75	50	6	30-75	47
Orderlies.....	12	50-80	60	12	40-75	56
Maids for floor work (with board and room).....	15	30-65	47	17	25-65	41
Maids (without board and room).....	3	50-65	55	4	40-65	55
Laundry man or woman (with board and room).....	12	40-300	106	13	40-125	67
Laundry man or woman (without board and room).....	7	85-200	140	6	90-175	133
Laundry help (with board and room).....	14	40-75	52	11	25-70	40
Laundry help (without board and room).....				9	35-80	48
Matron.....	12	50-125	69	13	30-95	57
Office employees.....	19	70-180	110	18	65-125	87
Clerical help.....	16	65-150	83	15	35-110	71
Telephone help.....	14	45-90	70	9	35-85	55

sent out a questionnaire to 110 of the larger hospitals of Chicago and the balance of the state of Illinois. I received replies from forty-seven different superintendents and from these, I have prepared the salaries per month in the above table. Salaries of superintendents are not given, as this phase of the subject was covered by Mr. Joseph J. Weber, editor of THE MODERN HOSPITAL, published in the issues of that magazine dated Oc-

CORRECTION

In the article "The Increasing Cost of Operation of U. S. Marine Hospitals," the first sentence at the top of the first column, page 497 of the May issue should read: The daily average cost per patient in marine hospitals for the fiscal year 1923 (instead of 1913) was \$4.08.

Dr. A. C. Bachmeyer, superintendent, Cincinnati General Hospital, Cincinnati, Ohio, has been secured by the Welfare Council of Cleveland to make a survey of the internal operation of the hospitals of Cleveland.

*Presented before the first annual convention of the Hospital Association of the State of Illinois, Chicago, April 10, 1924.

A CLINIC ON HOSPITAL REPORTS*

As stated in the first clinic (THE MODERN HOSPITAL, March, 1924) the examiner bases his judgment of the usefulness of hospital reports on the following tests:

(1) Does the report have informational and educational value for the average citizen, and is it presented in such a way as to stimulate his interest and enlist his cooperation for community health?

(2) Does the report present its financial statistics in such a way that the administrative officer or fiscal supervisor can demonstrate the adequacy of a budget and the propriety of expenditures for all of the various phases of hospital service; and are such statistics comparable with those of similar institutions?

(3) Does the report furnish professional workers within and without the hospital staff sufficient information on the efficiency of professional care of patients and the relation of hospital service to community health needs?

The director has endeavored in his notes to keep these questions in mind, but has not attempted to obtain, in all cases, categorical answers to them. He has attempted rather to express a somewhat impressionistic word picture of each case without making a complete diagnosis or prescribing the complete regimen of treatment.

Five reports have already been reviewed in the March and April numbers of this journal. It is perhaps too soon to obtain the benefit of criticism by readers, but the director continues to hope that such criticism will shortly be forthcoming from others interested in hospital reporting, to the end that these clinical notes may be made more helpful.—C. E. McCOMBS, M.D.

Clinical Notes

Case No. 6 (A General Hospital)

THIS report for 1922 of a hospital, conducted by the Sisters of Mercy in a large southern city, presents all of the customary defects of hospital reports, many of which have been discussed in previous clinics. For the layman it presents little of interest. Its eighty-three pages are devoted in the main to an enumeration in all detail of the ailments of patients complete from "abrasion" to "varicose veins." The brief summary tables of the results of treatment indicated by the condition of the patient on discharge mean little to the reader because he is left uninformed as to the relative importance, medically or surgically, of the items of this extensive catalogue of anatomical and pathological titles. It would be of interest to him perhaps to know something of the nature of the causative factors responsible for the conditions treated, such as alcoholism, acute and chronic poisonings, industrial diseases and injuries, automobile and other street injuries, etc. With respect to these and other conditions with which the layman is not wholly unfamiliar would it not be well for hospitals generally to present in their reports some of the evidence which will relate the subject of disease and injury to community life? Even in the presentation of highly technical matter there is an opportunity for interesting the layman that has generally been overlooked.

Financial Status Not Disclosed

The report offers no information whatever on the hospital finances except that it suggests that endowments and contributions will be welcomed. It is possible of

course that this hospital is under no obligation to the community as a whole for its support, but the examiner believes that no matter how a hospital may be supported, it should, as a public utility, open its books of account to public review. One of the most vital problems in hospital service today is that of hospital financing, and the hospital that fails to render a public accounting of its work is likely to find it difficult to open the public purse.

As a whole, the report viewed from any angle is disappointing. The fact that there were 5,375 patients treated in the hospital rooms and wards may or may not indicate efficient hospital use. How many of such patients were free, part-pay or pay? What percentage of possible hospital bed use did all of these patients represent? What was the relative percentage of free and pay service in the year reviewed and how did this compare with previous years? What did the patient have to pay for private room, semi-private room or ward service? What was the cost per patient day in the year reviewed and in previous years? How many of these patients were children and how many adults and what was their age and sex distribution? What were the sources of reference of patients? How many of them were public charges cared for at city expense or at hospital expense? These and many other questions should be answered for the information of layman, doctors, nurses, social workers and others concerned.

This is a rather sketchy summary of the report of a hospital that has, as the examiner knows, a high standing in its own community, but the sketchiness of our review is the result of our inability to find in the report anything that warrants commendation. Of course it is unfair to judge the competency of a hospital service by its reports, but it is certainly true that a hospital cannot serve its community to the best advantage unless it recognizes and seizes its opportunities to educate that community.

Case No. 7 (A General Hospital)

This report for 1923 of a general hospital in a suburban area of New York City is almost the exact antithesis of the report just previously considered. It is brief, only forty-seven pages, and yet omits very little that is essential. It is well edited and well arranged and full of suggestion not only to the statistician, but to lay and professional workers. Its general statistical summaries cover ten years of service and like the oft-cited petticoat are short enough to be interesting and yet long enough to cover the subject. Its illustrations are well chosen, and well placed throughout the text. The financial statistics for the year reviewed follow in outline the recommendations of the American Hospital Association medical and surgical diagnoses; causes of death and nature of operations are summarized briefly but satisfactorily.

Certain features of this report deserve more than passing comment. A table of contents at the front adds to its usefulness. Then following the list of staff and committee membership, there is "A Condensed History of the . . . Hospital" which carries the reader year by year from 1861 to date with a brief interesting note of the accomplishment in each year. It is a record of achievement that even the most casual reader will find worthy of his respect—and a good suggestion for hospital report makers anywhere.

The superintendent's report is a clean-cut statement of what the hospital has, needs and does. It is not the usual

*This is the third of a series of clinics on hospital reports conducted by Dr. Carl E. McCombs. The two preceding clinics appeared in the March and April issues.

platitudinous expression of acknowledgment to boards and committees but a business-like review of the hospital's work such as a good executive ought to submit to his directors. The reports of his subordinate officers give the same impression.

The "comparative statement" covering the period 1914 to 1923 inclusive is the sort of statement that one would like to see in every hospital report. It covers numbers of patients, patient days, free and pay, total operating expenses, receipts from patients and other sources, total earnings from all sources, annual deficits, cost per patient day, etc. It enables the busy reader to form almost at a glance a clear and impressive picture of trends in quantity and cost of service.

The only criticism the reviewer has to offer of this report is that it does not furnish sufficient information about bed capacity, distribution of beds by wards or rooms and by services. It is believed that such information would improve the report by making it possible for the superintendent to reinforce his argument for increased bed capacity, particularly for pay patients. The basis of his argument is not clearly laid, for in the "comparative statement" it appears that in the year 1914-15 pay patient days were 19,112, while in 1922-23 there were 19,198 pay patient days,—only eighty-six more. Considering both free and pay days there were actually about 5,000 fewer patient days in 1922-23 than in 1914-15, yet he states that "some action must be taken looking to the increasing of our bed capacity in order to meet the needs of the community." In the entire ten-year period, the year 1922-23 shows, according to the "comparative statement," the lowest total of patient days with the exception of the year 1920-21. No explanation is advanced of the reasons why there is need for more beds in the face of an apparently diminished demand for service. The explanation probably lies in the distribution of beds—but this fact should be made clear.

Case No. 8 (A General Hospital)

This is the report for 1923 of a fifty-two-bed general hospital in a small western industrial city. Its brevity, only fifteen pages, commends it, and the modest "Foreword" and "Something About Your Hospital," immediately following, serve to put the reader *en rapport* with the hospital's aims and ideals.

As has been previously noted in our comment, much of the usefulness of a hospital report, from the layman's point of view, depends upon the first few pages. If his interest is aroused he may perhaps be induced to read on through statistics that might otherwise bore him. "Something About Your Hospital" in this particular report is exactly the kind of thing needed in hospital reports for general distribution. It tells the reader when the work was begun and the aims of its founders; what the hospital plant comprises and how it is equipped; what its room and ward rates and other charges are; its rules regarding visiting and other matters; the members of its board of trustees and of the medical and executive staff; what it is endeavoring to do to meet the standards set up by the American College of Surgeons, etc.

Detailed Financial Statement Needed

But following this excellent introduction the reader comes upon a financial report of current operations that shows only total income, total expenses and an operating deficit of over \$5,000 for the year. In this connection a detailed statement of revenues and expenditure, according to the recommendations of the American Hospital Association, would be of interest to contributors and citi-

zens in general. It would appear also from the financial statement that about \$1,000 for "extensive repairs to heating plant made in 1922" was included in the total operating expense. To include such items of capital outlay in operating expenses does not, of course, permit a fair comparison of patient day costs with those of other hospitals whose costs are more accurately determined. This is not an uncommon error in the financial statements of many small hospitals.

The chief criticism of this report is, however, that it has completely overlooked the question of patients except as to their total number and their condition on discharge. Nothing is said of nature of diseases and injuries treated, of operative procedures or any other matters that would permit judgment of the quality and quantity of service in the various fields of hospital work. Such information would help to sustain the request of the board for contributions to meet the need for special therapeutic equipment desired, and to indicate some of the problems of community health service with which the hospital should be vitally concerned.

The report is illustrated but the pictures do not add greatly to its value. A group picture of nurses is pleasing, but pictures of a sterilizer, an x-ray outfit and a somewhat gruesome operating room scene might well have been left out. The use of illustrations which add considerably to the cost of publishing a report is certainly inadvisable unless the illustrations are stimulating to the reader's imagination and have some direct application to the text.

COURT GRANTS PHYSICIAN USE OF HOSPITAL FACILITIES

The decision rendered by the Supreme Court of New York in the Van Campen case, April 7, 1924, restored to Dr. Benjamin Van Campen the right to operate upon and care for his patients in the Olean General Hospital, Olean, N. Y., but did not reinstate him as a member of the staff.

Dr. Van Campen was dropped from the staff of that hospital December 19, 1923, because "his conduct did not become the orderly conduct of the hospital." The action, Judge Alonzo G. Hinkley, Buffalo, states, was the result of petty differences which arose between the plaintiff and the employees of the defendant.

The question at issue was whether or not the hospital had the right arbitrarily and without cause to refuse to a physician and surgeon the right to use its hospital facilities and require his patients to employ members of its visiting staff, or go elsewhere for hospital care. In the case of the city of Olean, the hospital in question was the only one, save a private sanitarium.

Dr. Van Campen believes that his reinstatement as a member of the staff will follow this decision, as one of the requirements of the hospital is that when a physician practices at the hospital he necessarily becomes a member of the staff.

SUMMER COURSE IN PUBLIC HEALTH WORK

Courses leading to advanced degrees and giving credit in public health work will be offered at the summer sessions of Columbia University, and the state universities of California, Iowa and Michigan. The session at the University of Iowa will be from June 9 to July 18; at the University of California and University of Michigan, from June 23 to August 2; and at Columbia University from July 7 to August 15.



THE INFORMATION DESK

STERILIZING KNIVES BY HEATING IN LIQUID PETROLATUM

By ANNA L. GIBSON, R.N., SUPERINTENDENT, COLLIS P. HUNTINGTON HOSPITAL, HARVARD MEDICAL SCHOOL, BOSTON, MASS.

PROPER sterilization of knives, needles, and scissors, is a subject frequently discussed by nurses and surgeons. It is a well-known fact that sterilizing the instruments by boiling inevitably destroys the edge and causes them to rust; and it has been repeatedly demonstrated that the method of sterilizing knife blades, scalpels, and scissors, previously cleansed in soap and water and then placed in seventy per cent alcohol for ten or more minutes, does not kill organisms.

The oil method used at the Collis P. Huntington Hospital, Boston, Mass., is one which has been thoroughly tested by Dr. Henry Lyman, and found to be reliable.

The instruments are sterilized by heating them in liquid petrolatum at 120° C. for twenty minutes. The knives, scissors, and needles may be left in the petrolatum for an indefinite period without danger of rusting. The needles so treated retain their sharpness and can be resterilized many times without losing their points. The oil, which may be considered as dry heat, destroys the organisms as quickly at the same temperature as does boiling water.

By a series of careful experiments Dr. Lyman found that staphylococcus pyogenes-aureus and albus were killed in ten minutes at a temperature of 105° C. and that anthrax spores, the hardest form of life to destroy, were killed in ten minutes at 150° C. The staphylococci were killed at 150° C. in fifteen seconds.

To obtain the best results, the oil used must be clear so that the instruments can be easily seen, non-irritating, chemically inert, and must have the highest possible flash point on account of danger from fire. Liquid petrolatum fulfills all the conditions; but it is expensive, although it may be used over again indefinitely. There is a so-called cutting mineral oil, although somewhat yellow, which is an excellent substitute. Dr. Lyman considers that any non-irritating hydro-carbon lubricating oil of good grade would answer the purpose.

Thermometers may be used to determine the heat, but they are easily broken; the simplest way of telling when the oil bath has reached 150° C. is by an indicator. These indicators are small glass ampules containing chlorid iodid of mercury, such as was used in Folin's method for determining urea. The indicator is placed in the coolest part of the sterilizer. This salt in the ampule is a red powder at room temperature, turns yellow at 118° C.,

and melts to a clear amber fluid at 155° C. It is necessary to keep the indicator melted for ten minutes.

When the oil is heated very hot it will smoke and smell somewhat, therefore it is advisable to turn the heat partly off after the indicator becomes yellow. Nickel-plated boxes with closely fitting covers may be used as receptacles. The instruments are placed in the boxes, completely covered with the oil, the indicator placed at one end, and heated over a Bunsen burner. They should be resterilized once in two weeks.

MANAGING NIGHT NURSES' SUPPERS

One of the most difficult problems common to all except the largest hospitals is that of providing good mid-night suppers for the night nurses. The Children's Hospital, Washington, D. C., has found what seems to be a satisfactory solution.

The hospital has but seven night nurses, although there are usually several special nurses who are up at night. The night fireman is the only man available for orderly service.

The diet kitchen force consists of two full-time and one half-time nurses. One of these, in turn, reserves two hours of her time for preparing night suppers. She begins that work about 10:30 p. m., prepares a tray for each night nurse, and sends it over by the night man. The result is dainty food attractively served, because it is prepared by one who through experience appreciates the requirements of the case. It is possible to provide special diets in this way, without much additional trouble.

When convenient for the diet kitchen, the nurse who prepares the night suppers sleeps late the next morning. If not, she (presumably) takes an afternoon nap. There are very few hospitals that cannot spare two hours of one nurse's time in so good a cause.

STERILIZING BOOKS USED IN A CONTAGIOUS DISEASE HOSPITAL

The question of what is the best method of sterilizing books used in a contagious disease hospital has been brought up by several of our readers. One inquirer asks if there is a dry method of sterilization which is better than the ordinary steam sterilization.

Dr. D. L. Richardson, superintendent, Providence City Hospital, Providence, R. I., makes the following reply:

"The sterilization of books without injury to them is a difficult task. It is our practice here at the hospital to sterilize all the mail sent out by patients. We do this in a small autoclave. If the sterilizer apparatus is efficient and if the jacket of the sterilizer is certainly filled with steam, and if after sterilization the door of the sterilizer is not opened at once, before the interior is allowed to cool, then the sterile goods should come out dry. We find that the letters come out in very good condition. We are also sterilizing some books by the same method, and if they are sterilized properly they also are damaged very little, sometimes not at all.

"I do not know very much about dry sterilization. If done properly, I believe that it is efficient but it has been our experience that dry heat is likely to cause more damage than ordinary autoclave sterilization properly done. It turns the leaves brown and if the heat is excessive it spoils the edges. Dry heat over a protracted period may be used without damaging the book, but this would be a form of pseudo-sterilization. Sometimes we depend entirely upon putting books out and exposing them to sunlight and the drying effect of the air, but I would not advise a public librarian to send books to a contagious hospital and take them back without sterilization.

PLAN FOR HANDLING PRINTED MATTER

One hundred and twenty printed forms and blanks are used for various purposes in the Jewish Hospital, Cincinnati, Ohio. This large and varied supply is kept in the stock room which adjoins the office of the purchasing agent, and when a department needs a supply of a certain blank the requisition comes to this division.

As may be seen from the accompanying illustration, which shows several of these forms, there is an identifying mark in the upper left-hand corner of each sheet. The

"Receiving Record," for instance, is marked "Form 22, 1 M, 11-21." Translated, this means that 1,000 of these blanks were printed in November, 1921. In the same manner the line "Form 64, 10 M, 1-23" shows that 10,000 of these, the blanks for "Daily Report of Patients," were printed in January, 1923.

Each blank is assigned a number, and by this number it is known, not by a title. The person who needs an additional supply of a given form indicates it by its number, and no mention of its name or purpose is necessary. Thus, if one desires a supply of the "Daily Report of Patients," this title is not used, but the request is for a stated quantity of "Form 64," or if blanks for "Requisition of Repairs" are needed the request is for "Form 10."

All of the blanks are arranged in numerical sequence on shelves in the stockroom, each of the 120 forms being assigned a specific place, with ample room for the maximum number that are to be stored. Large numerals on the shelves indicate the location of the different forms, and this enables the stock-keeper to locate quickly the desired blank and secure it without disturbing the rest of the stock. As all of the stock on hand is visible, the stock-keeper can readily see what forms need replenishing as the stock is used up. Therefore there is not the sudden and inconvenient giving out of much-needed forms which so often occurs when printed stock is stored in the usual manner.

A copy of each form is kept in a large scrap-book, these also being arranged in numerical sequence. As soon as a new supply is ordered a notation is made in the book, near the form, and as soon as a new lot is received one of the forms is inserted in the book. This system offers several advantages, some of which are: (1) Those who desire a blank need not use its name, but merely designate it by number; (2) when a blank is desired, there is no hunting through the entire stock, for it will be found in a certain location on a certain shelf, clearly indicated by a number; (3) all stock is in sight, and it is easy to see whether replenishment is needed; (4) there is no wastage of stock through its being soiled and torn by constant handling.

WASTE IN CLEANING PREPARATIONS

An item of cleaning gear which is often wasted by employees of the hospital is cleaning or polishing cake preparations. When these cleaners are used for windows often a cake will be divided among several men and, as a result, the remnants are not collected but eventually find their way to a trash can. It should be remembered that a small quantity of kerosene or turpentine cleans the windows just as nicely as many of these preparations, costs much less and leaves no white particles in the corners of the frames, and the glass has a higher polish.

JEWISH HOSPITAL RECEIVING RECORD					
STORE ROOM				STORE KEEPER	
DATE	ARTICLE	QUANTITY	FROM (FIRM NAME)	REMARKS	
Form 64 10M 1-23 Department _____ Date _____ 192 _____ Daily Report of Patients					
NAME	TESTED	CONDITION AND REMARKS	DOCTOR		
Form 99-104 11-32 THIS SLIP MUST BE IN SUPERINTENDENT OF NURSES DESKS BEFORE 2 P. M. EACH DAY Floor _____ Date _____					
ROOM NUMBER	BREAKFAST	DINNER			
Form 101M 4-21 THE JEWISH HOSPITAL REQUISITION FOR REPAIRS Requisition for Repair of Buildings, Furniture, Fixtures, Etc., requiring immediate attention to Date _____ 192 _____					
Form 111-100 6-20 JEWISH HOSPITAL Date _____					
Form 12 10M 1-23 JEWISH HOSPITAL DISCHARGE SLIP TO OFFICE Date _____ Hour _____ Name of Patient _____ Room or Ward _____ Discharged _____ M. Transferred to _____					

Some of the blanks used by the Jewish Hospital. Each form has an identification mark in the upper left-hand corner.

NURSING AND THE HOSPITAL

Conducted by CAROLYN E. GRAY, R.N.,

Dean, School of Nursing, College for Women,
Western Reserve University, Cleveland, Ohio

THE HOSPITAL SUPERINTENDENT'S RELATION TO THE SCHOOL OF NURSING

BY SISTER M. JOSEPH, R.N., SUPERINTENDENT, ST. MARY'S HOSPITAL, ROCHESTER, MINN.

WITH the development of the modern school of nursing, we find that the distinctive work of the hospital is carried on largely by the personnel of the training school. It follows, therefore, that the welfare of the school is one of the most important responsibilities of the hospital superintendent.

The superintendent of the school of nursing, her assistants, and their students, owe no apology to the hospital for being a part of it; on the contrary, the hospital is greatly indebted to them. Our tendency to forget sometimes causes us to lose our bearings in regard to our schools of nursing and we have to orient ourselves anew. We may already have forgotten that during the World War many hospitals had to close their doors because of the lack of training schools and the shortage of nurses. Casual studies made to determine the economic relation of the school of nursing to the hospital show that the school is an asset. Even should it be otherwise, it has, in the eternal scheme of things, a value that money cannot measure.

Through its school of nursing, the hospital serves not only the present by taking care of the sick here and now, but also the future by preparing a new generation of women to carry on its noble work. It is an educational force that gains in momentum with each succeeding day, for every nurse, no matter in what field she practices her profession, is a teacher. She is a teacher of health no less than a nurse for the sick. Consciously or unconsciously, she is a light bearer, and the strength of her authority is attested by the oft heard expression, "The nurse said . . ."

How is the hospital affected by the continual line of pupils passing through its doors? The presence of eager, hopeful, ever-enquiring students, creates an atmosphere of investigation, study, and buoyant life which reacts favorably on the institution. They are to it an elixir of youth. The freshness of their outlook, their untroubled hopes, the ardor and generosity with which they enter their chosen field of service, have a tonic effect on the whole nursing corps. Under proper supervision the well trained student nurse leaves nothing to be desired in point of service; and when, as not infrequently happens, a patient who has had experience of her worth, requests information regarding the school of nursing, because he has a daughter or a sister who might enter it, the educational value of the school has manifested itself in

a way that has proved very profitable to the hospital.

The social value of the school of nursing is inestimable. It trains a large number of women not only for personal efficiency, but also as members of the advance guard of social welfare and progress. It educates them definitely for social service. It imbues them with a spirit of helpfulness; it fits them for domestic efficiency; it develops their appreciation of useful measures for community welfare and prepares them for practical citizenship. More than any other institution for the professional training of women, it fits them for usefulness in womanly spheres outside of their own profession.

Superintendents Need Formal Training

The welfare and success of the school of nursing depend on two officials chiefly: the superintendent of the hospital and the superintendent of the school. Between them there must be harmony of aim and effort in all that pertains to the students and their work. The superintendent of the school, with visions of the future, has devoted time and money to preparing herself for her important work; she has probably made many sacrifices to fit herself for it. If professional training is admittedly necessary for her, is it not consistent to ask that her superior officer should have at least some training along hospital lines? Often his attitude is decisive in regard to the personnel of the teaching staff, disciplinary methods and measures, financial outlay for educational purposes, and the general policy of the hospital. Only a trained hospital superintendent can appraise the merits or demerits of his staff and cooperate intelligently with his subordinate officers. He needs to have clear ideas of all problems of hospital management, particularly those of the school. Lacking formal training, he must needs possess a spirit of docility and a sweet simplicity, cautious at the same time that his simplicity is that of the dove, not of the goose.

The problem of the hospital superintendent is not merely the sum of the problems that he acts upon day after day. The superintendent himself is a part of the problems of superintendence. Occasionally he needs to be cured of a rabid idea. Always he needs facts, principles, ideals, and attitudes. Relative to the school of nursing, these facts, principles, ideals, and attitudes, should be imparted to him by the superintendent of the school. If his policy is a detriment, she cannot conscientiously

content herself with proclaiming his real or alleged iniquity, for the interests of both school and hospital demand her best constructive efforts to correct his views or avert their ill consequences.

What We Owe Our Students

Hospital superintendents and all who are connected with the education of our student nurses, would do well to bear in mind that, generally speaking, our students are actuated by high motives in choosing their profession; they have a vocation; the ideals to which they aspire are heaven-born, a gift from Him who sacrificed Himself for the human family. They devote three of the best years of their lives to preparing themselves to render noble, useful, humanitarian service; they carry on a large part of the work of our hospitals; we are better off for their presence among us. What are our obligations in return? We owe them a warm welcome to our schools; the comforts and refinements of a good home; training that will qualify them for the highest efficiency in their profession; the inspiration of lofty ideals. In our business and social relations and in every phase of our conduct, we should be to them an exemplification of what is noble, honorable, inspiring. They should find our service to humanity sincere, whole-souled, and free from the taint of commercialism.

Too frequently hospitals, on account of financial pressure, fail to provide adequately for their schools of nursing. The capable hospital superintendent will soon find a way to remedy such a situation. He will regard the cost of the school as a legitimate and profitable hospital expense; he will make allowance for the ever-existing need of improvement, knowing that nothing is permanent but change, that every profession must continually adapt itself to the changing needs of society, and that the nursing profession must keep pace with the advancement of medical and surgical science as well as with developments in hospital methods and technic. The capable hospital superintendent fosters enthusiasm among instructors and students; his criticisms are constructive; he urges improvements; he has faith in the head of the school and gives her his unwavering support. He is an educator and an administrator, and finds in his dual capacity an

opportunity worthy of the best that is in him.

To summarize: The hospital superintendent is an important factor in the success of the school of nursing; in order that he may deal successfully with problems of hospital administration, including the school of nursing, he should be trained along hospital lines; he should be keenly aware of the value and importance of the school of nursing, and should contribute to its proper functioning; he should realize that we owe the students something more than an opportunity to work; his management of the hospital should exemplify honor, justice, and fairness, and so be an edification to the students; he should be ambitious to equip the school with the best teaching facilities and to provide the pupils with comfortable living; he should be proud of his relation to the school and humble with a sense of his responsibility.

CHANGING ONE'S MIND

Changing one's mind is always an interesting process. At times it is very difficult and the creaking of the mental machinery is almost painful. At other times it happens almost unconsciously, and the realization of what has happened is rather surprising. A recent visit to Rochester, Minnesota, furnished opportunity to meet the renowned Dr. C. H. Mayo whom the writer found an approachable, democratic type of man. His ideals and aims in regard to nursing education were quite as advanced as those of our foremost leaders, and the writer found herself a bit nonplussed because they were so different from what she had expected. Much reflection on this experience has confirmed her fear of hasty conclusions and her belief that better understanding of each other's aims and ideals would show that we are nearer together than sometimes appears, particularly when our statements are interpreted or misinterpreted by those who have no appreciation of the problems involved.

It was a privilege to be present during several operations performed by Dr. Mayo. It would take an expert surgeon to do justice to Dr. Mayo's skill, but from a nurse's standpoint, the outstanding features were, first, an utter absence of tension, everyone seemed at ease; second, remarkably simplified technique; and last but not least, a student nurse was "clean nurse" and actually served Dr. Mayo! To those of us who have tried to persuade the "powers that be" that student nurses are entitled to this experience and have found even interns demanding the services of graduate nurses, it was refreshing to find that a great surgeon found the service of student nurses who had been properly taught and were carefully supervised, quite satisfactory.

Is it not something to be thankful for, that such happy surprises justify "changing one's mind" most decidedly?

C. E. G.

PROGRAM FOR CATHOLIC NURSES

The guild of Our Lady of the Visitation at Detroit, Mich., has arranged the following program to welcome visiting Catholic nurses who come to the American Nurses' Association convention. On June 18th, at 8 o'clock in the morning, there will be a communion breakfast for Catholic nurses following mass at the Church of Our Lady of the Rosary, Woodward and Medbury avenues, Detroit. At the breakfast, the Reverend E. F. Garesché, S. J., spiritual director of the International Catholic Guild of Nurses, will speak on the plans for the guild. On Thursday evening, June 19, a meeting of the Catholic nurses will be held at the Providence Hospital auditorium, at which Father Garesché will again speak to the guild. This will be followed by a discussion, a musical program, and a reception for the visiting

Catholic nurses under the auspices of the guild.

OFFERS TWO NURSING COURSES

Two courses in nursing will be offered at Western Reserve University this summer, one in administration and supervision in schools of nursing, and the other in teaching in schools of nursing.

A description of these courses and also of courses offered in education, psychology, English, history, etc., are found in the summer session catalogue. The summer session opens Monday, June 23, and continues until Aug. 1.

THE DEVELOPMENT OF NURSING IN CHINA

By CORA E. SIMPSON, R.N., GENERAL SECRETARY, NURSES' ASSOCIATION OF CHINA, SHANGHAI, CHINA

CHINA, with her vast country, reaching from snow-capped Manchuria to sun-kissed Kwangtung and from bustling Shanghai to the dizzy heights of Tibet, with her five thousand years of history and her population of four hundred million people, where live one-fourth of the world's population, where one third of the earth's babies are born, where every disease known to mankind runs riot and where sanitation is unknown, this vast land presents one of the most inviting fields for the work of the nurse today.

This is the one country in the world where nursing was an unknown art until Christian nurses came to develop it. For nursing in China was started and brought to its present state of development by missionary nurses, and it is still in their hands. The record of the work is unparalleled in the nursing history of the world.

On a rainy day in March, 1884, Miss Elizabeth Mackechnie (Mrs. Thompson) arrived in China and began her work at the West Gate Hospital in Shanghai. There were mission hospitals and doctors before that time but it was not until after 1900 that many nurses came to take up the work.

When I came in 1907 there was no nurses' association; there were no schools of nursing, no text books and not even a word in the language for "nurse." I sent a letter to Dr. Cousland in 1908, about nurses' work. This letter and his reply were published in leaflet form and sent out to all the hospitals, doctors and nurses working in China, making known the need for a nurses' association. This was the real origin of the association and the work was started the next year, with Mrs. Hart of Wuhu as president.

Medical Association Honors Nurses

In February, 1910 by special invitation from the doctors I attended their medical meeting in Hankow, and shall never forget the interest shown, and the courteous treatment, extended to me by the doctors present. This friendship for the nurses' work has developed through the years until at our recent conference the medical association honored the nurses by sending their president and secretary as delegates to the conference.

In the early days very little was accomplished until a special meeting of delegates was called at Kuling in 1912, when plans for the registration of schools of nursing, with a standard curriculum and national examinations, were mapped out.

The first text book on nursing was "Principles and Practice of Nursing," by Isabel Hampton Robbs, translated by Dr. Eleanor Chestnut. Many other books have followed until now we have a splendid list of books for our schools of nursing.

At the first national conference, held in Shanghai in 1914, the word for "nurse" in the Chinese language was adopted by the association and has since passed into the literature and language of the people.

The first national examination was given in 1915. There were three successful candidates—two men and one woman. Since then 736 diplomas have been issued to nurses, and thirty-two diplomas in special midwifery. These examinations take the place of those held by the state boards in other countries, and nurses cannot receive their own hospital school diploma until they have passed the examination and received the diploma of the associa-

tion. The curriculum is taught entirely in the Chinese language. English is taught as an elective in some schools. There are now ninety registered schools of nursing, thirty having been registered in the past year and a half. They are found in almost every province in China, and are co-educational, the students being about equally divided between men and women.

Association Attains Highest Honor

Our little quarterly journal was launched in 1920 and is the official organ of the association. It is known today in nursing circles in every country in the world and is supplying a great need in keeping the nurses in touch with each other in this vast land where distances are so great and travel so difficult and dangerous.

From the year 1922 great forward steps have been made. A full time secretary was elected and has given all her time to the work. In 1922 the association was admitted to full membership in the International Council of Nurses, which is the highest honor and greatest privilege that can ever be enjoyed by any nurses' association. At the next meeting of the International Council of Nurses, to be held at Helsingfors, Finland, in 1925, four official delegates from China will be present.

In 1923 the association was invited to become a member of the Council on Health Education for China, and is now, through her nurses, teaching health, sanitation, baby welfare and home nursing to this great people.

At the conference in 1922 one hundred and thirty-two members were reported. We now have a membership roll of 850 and applications for membership are coming in every day. More than half of this number are Chinese nurses and in the future they will be in the majority, as the foreign nurses coming in will not equal in number the Chinese graduates, to whom the association will eventually belong, as we have planned from the beginning that it should.

Our graduates enter all branches of nursing as do nurses in other lands—army, navy, factory, school, baby welfare, public health, maternity, tuberculosis. They act as superintendents of schools and hospitals, as supervisors and anesthetists; they share in hospital work in all its branches. The demand far exceeds the supply. Our nurses' work is no longer on trial but is fast becoming a national power.

China Friendly Toward the Nurse

This year I have visited the schools of nursing in China. This has carried me into almost every province and has necessitated travelling by all kinds of conveyances known to humanity. The unsettled political condition has made the journey dangerous and, at times, nigh impossible, but all the places have been reached, and the joy of meeting the nurses and bringing cheer and encouragement to them, and the satisfaction of seeing how the work has grown and developed has more than compensated for the difficulties and dangers of the travel.

What matter bandits, sleeping in inns already inhabited by creatures who never pay rent, days and nights under the stars, dirt, rain, cold, sand storms, blinding heat, disease infected districts, discouragements, misunderstandings, opposition and all the other difficulties we have met—what does all this matter if the association has grown and the little Chinese nurses are coming into their

own. It has been and is a joy to work for them.

The Chinese have always shown a friendly attitude toward the nurses. President Yuan She Kai gave to Miss Elise Mawfung Chung, the first Chinese nurse trained abroad, a gift of money with which to publish her book on nursing. The officials are always ready to help in the public programs. One governor said the nurses are the teachers of sanitation and guardians of the public health and have brought a religion we can all understand—that of service to mankind. Wu Ting Fang, at his own request, spent his last days in a Christian hospital, so that he could be cared for by the Chinese nurses there.

At the nurses' conference held in Hankow the governor of Kwangtung sent six Chinese nurses as his delegates. The governor of Hupeh Province responded by sending eight nurses as his representatives to the next conference held in Canton.

General Feng Yu Hsien wants only graduate nurses for his army and has a nurse especially trained in midwifery to care for the women and children in the camp. At the last conference held in Canton the Chinese nurses were there in large numbers as delegates. The superintendent of nurses at the Canton Hospital, the first Protestant missionary hospital in the world, is Miss Lau I. Oi. Miss L. Wu is superintendent of nurses at the Red Cross hospital in Shanghai and Miss L. Li of the Women's Hospital in Anlu Hup.

As a mother glows with pride over her grown sons and daughters, so we rejoice over the success and triumphs of our Chinese graduate nurses. This is their country. The association was started for them. For them the books were translated. For them the schools were established and the examinations held. Caring for the sick people of China is their task. They will take the ideals of nursing we have brought to them and fit them to China's needs and will, no doubt, have much to contribute to the nursing profession in future years.

As we see these graduates of ours, and the work they are doing and the places they are filling in China, our hearts are glad, and we forget all the tears and the trials of the early days as we look into the future and see them assuming places of trust and responsibility, and eventually carrying on the work of the association and making it a blessing to China. This will be enough; we shall be content to have had the privilege of starting this work in the land of our adoption and among the people we love.

FIRST ANNUAL MEETING OF CATHOLIC NURSES TO BE HELD JUNE 21-28

The first annual convention of Catholic nurses will be held at Spring Bank, Wis., June 21-28 preceding the meeting of the Catholic Hospital Association which will have headquarters there June 30-July 23. A retreat conducted by the Rev. E. F. Garesché, S.J., St. Louis, Mo., will be held June 21 to 24. An organization conference will then be held to approve the constitution and by-laws and elect the officers of the International Catholic Guild of Nurses. This will be followed by a program of papers and discussions by graduate nurses.

Among the subjects which will be discussed are: the Catholic nurse and her reading; the Catholic nurse in public health work; industrial nursing; what every nurse should know about mental cases; the opportunities of sodality membership for nurses; the nurse as a hospital superintendent and assistant; the open retreat for nurses; the Catholic nurses from the viewpoint of the patients;

training for nursing eminence; the Catholic lay nurse and her opportunities for service to God and humanity; art culture for nurses; what the Catholic nurse should do for the grievously ill; remedial social work by graduate nurses; tuberculosis nursing; contagious nursing.

June 26, 27, and 28 will be days of informal conference and recreation, and excursions to points of interest in the neighborhood.

PROGRAM OF NATIONAL BIENNIAL NURSING CONVENTION

Plans are being completed for the biennial convention of the three national nursing organizations, at Detroit, Mich., June 16-21, which promises to be the largest gathering of nurses ever assembled in this country. Institutional nurses and those engaged in the various fields of nursing service from all sections of the country are expected to attend the convention.

The tentative schedule of the six-day program is filled with papers and discussions of nursing problems which are closely related to those of hospital.

The tentative program follows:

Monday, June 16

- 9:00-11:00 Business session, National League of Nursing Education.
- 11:45-12:45 Business session, National Organization for Public Health Nursing.
- 2:30- 4:30 Business session, American Nurses' Association.
- 8:00-10:00 Opening session—joint meeting—American Nurses' Association, presiding.
- "The American Red Cross Nursing Service," Clara D. Noyes, R.N., national director, American Red Cross Nursing Service, Washington, D. C.
- "Woman's Relation to World Peace," the Hon. John H. Clarke, former associate justice, U. S. Supreme Court.

Tuesday, June 17

- 9:00-11:00 Joint session—American Nurses' Association, presiding.
- "The Role of the Physician in the Education of the Nurse," Charles D. Lockwood, M.D.
- 2:30- 4:30 Joint session—N. O. P. H. N., presiding.
- "Communicable Disease," Charles P. Emerson, M.D., dean Indiana University School of Medicine; Elizabeth F. Miller, R.N., superintendent of nurses, Philadelphia Hospital for Contagious Diseases, Philadelphia, Pa.

NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING SESSIONS

- 11:15-12:45 Organization discussion. "The Interdependence of the Physician and Public Health Nurse in County Health Work."
- 4:30- 6:00 Round table—"Visiting Nurse Study Reports," Chairman, Katherine Tucker, R.N.

AMERICAN NURSES' ASSOCIATION SESSIONS

- 11:45-12:45 Organization discussion.
- 4:40- 6:00 Round table—"A Useful Tool When Skillfully Used," *The American Journal of Nursing*, Chairman, Mary M. Roberts, R.N., editor.
- Round table—"Postgraduate Courses for Nurses," Chairman, Mary C. Wheeler, R.N., Illinois Training School of Nursing, Chicago, Ill.
- Round table—"State and Local Committees on Red Cross Nursing Service," Chairman, Clara D. Noyes, R.N.
- Round table—"What Women Need to Know Before Voting," Chairman, Mrs. Charles Novak.

NATIONAL LEAGUE OF NURSING EDUCATION SESSIONS

- 12:15-12:45 Organization discussion.
- 12:45- 2:30 Luncheon round table—"Legislation," Chairman, Janet Geister, R.N., research worker, Committee on Dispensary Development, New York, N. Y.
- 4:40- 6:00 Round table—"Publicity in Schools of Nursing," Chairman, Elnora Thomson, R.N.

Wednesday, June 18

- 9:00-11:00 Joint session—N. L. N. E., presiding.
- "A Study on Budgets for Schools of Nursing," Chairman, Elizabeth A. Greener, R.N., superintendent of nurses and principal school of nursing, Mt. Sinai Hospital, New York, N. Y.
- 2:30- 4:30 Joint session—A. N. A., presiding.
- "The Responsibility of the Community and the Hospital in the Establishment of a School of Nursing," Christopher G. Parnall, M.D., superintendent University Hospital, Ann Arbor, Mich.
- "The Responsibility of a University School of Nursing Toward the Hospital and Community," Mrs. Chester C. Bolton, Cleveland Visiting Nurse Association, Cleveland, Ohio.

NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING SESSIONS

- 11:15-12:45—Organization discussion—"Communicable Disease Nursing," Chairman, Alta E. Dines, R.N., director of

(Continued on page 630)

DIETETICS AND INSTITUTIONAL FOOD SERVICE

Conducted by LULU G. GRAVES,
Supervising Dietitian, Mt. Sinai Hospital, New York.

THE STRATEGIC POSITION OF THE DIETITIAN

By WINIFRED STUART GIBBS, EDITOR, *The American Food Journal*, NEW YORK, N. Y.

AMONG the first of the home economics workers to specialize, the dietitian, paradoxically enough, is an outstanding example that *rara avis*, the specialist who is concerned with the specialties of others almost as much as with her own.

Having won her well-fought fight for recognition as an integral part of the hospital staff, does she always realize that with this recognition may have come increasing responsibilities?

No one will question that the devoted dietitian visualizes her responsibilities within her own special field; it is with her possible powers for service outside her immediate circle that we are now concerned.

As "domestic science" broadened into "home economics" our technical schools ceased their indiscriminate herding of all students into one field, there to flounder until some chance encounter determined whether their ultimate destination were to be classroom or hospital, tea room or technical laboratory. Specialization from within was the leaven at work, and today we have the inspiring sight of women busily engaged in activities which are, to some extent at least, of their own choosing.

Because of this very fact may not the dietitian easily lose sight of parallel fields, to the enrichment of which she might easily contribute, if she would but give an occasional thought to the points at which her efforts and those of other workers come together?

Parallel Fields of Endeavor

Is it enough to see one's own problem whole, unless that problem is also envisaged in its relationships to the problem of the world? To be professionally minded is good, to be socially minded is better! Members of the American Dietetic Association themselves submit the following as the main divisions of the dietary department in a modern hospital: (1) Routine food service; (2) teaching pupil nurses and supervising diet nurses; (3) therapeutic work with technicians and patients.

What relation does each of the above bear to conditions as they exist outside the hospital walls?

What is the dietitian's part in helping to develop standards for American food?

Where does her work touch that of the laboratory? Of the class room?

What contributions may the dietitian make to the permanent literature of nutrition and to that of home economics in general?

How may she most effectively take part in that move-

ment the object of which is to make the words "home economics" connote constructive activities in world affairs?

These and kindred questions occur to the mind of one who has a passion for perfection within her own profession.

"But" says some one, "We are *not* home economics workers in the sense that the term is applied to educational projects."

"No? Not so?"

Larger Vision of Dietetics Needed

In her zeal for independence and unity within the confines of her own territory, is there a possibility that the dietitian may have lost hold of that larger vision, the field wherein the spirits of Mrs. Richards and other devoted pioneers still exert their potent influence?

"Nothing is fair or good alone," and the hospital dietitian who aspires to the highest achievements within her own field will succeed in proportion to the extent of her contacts outside that field.

While of necessity concerning herself largely with that phase of the question of standards that affects directly the welfare of her patients, may not the dietitian exert at least an indirect influence over food standards in general?

Progressive manufacturers are already eager to co-operate and it is a safe conclusion that they would welcome further suggestions as to possible team work in the interests of American food.

Naturally one thinks of any such activities as a by-product of the dietitian's work rather than as her chief responsibility. Her busy days hold small margin of time for outside contacts, and the following questions are raised with the idea of being merely suggestive. Looking from the outside anyone can easily envisage the dietitian as taking an active part in future activities that may be instituted for the benefit of public health, even as one sees her today in her active role of health purveyor to the individuals. And to consciously relate the results of the immediate day's work to the future may be stimulating to the dietitian, as it can hardly fail to be educational to the manufacturer.

Cooperation with Food Associations

Having won the confidence of the purchasing agent through whom her individual contacts with the commercial world are naturally made, the dietitian might find it worth while gently to lure this unsuspecting individual

to the point of welcoming systematic cooperation with the food trade associations that function in the interests of the various food products used in the hospital.

One can easily picture the good results that might accrue if the dietitian sent to the officers of the trade associations informal bulletins, setting forth first, her professional requirements in regard to each product; second, her reasons therefor, and third, her suggestions for improvements or modification.

This is far from partaking of the nature of police work such as years ago might have been necessary for the detection of adulterations. Progressive manufacturers have long since learned that it is good business as well as good ethics to produce pure food. Such cooperation as we have outlined aims rather to educate the manufacturer as to institution requirements in the matter of food-stuffs, just as other groups in the community are helping him to visualize individual consumer needs.

The dietitian herself is the only one who could possibly frame the questions that might advantageously be discussed; that she would be performing a social service by so doing may not have occurred to one whose whole life is spent in service of one form or another!

Dietitian as Social Service Worker

In some hospitals the social service worker is also a dietitian, but often she is not. Patients who frequent the out-patient department, or "O. P. D." (to adopt terse hospital parlance) offer unlimited opportunities for original work in nutrition. Naturally the dietitian has no time to spare to do this in detail, but may it not be possible for her to lighten the labors of the busy staff physicians and the social worker as well, by suggesting systematic work on the individual problems of these patients?

So often do they have a "history" of undernourishment! So frequently are they little children, hovering on that grim border-line between complete nutrition and its opposite, and young enough to make preventive work worth while!

One recalls the clinic patient who announced proudly that she could not take a lesson in food preparation because she had, according to the physician, "a touch of tuxedo!" Her actual ailment, "toxemia," was being taken care of by the physician, but her diet lessons helped materially in keeping up her general health, thereby hastening recovery.

Another visitor to the same clinic was a "chronicle bronchial," and again, *her* diet lessons offered to the physicians just so much more help in his efforts to restore her to health.

So, if our modern dietitian, who is ever and increasingly the executive, can find time to plan a course of training, for the social service worker, with a view to helping her solve a portion of her problem, she will be adding yet another stone to the edifice she is building. The lessons might be brief mimeographed notes, they might take the form of a primer-like pamphlet or they might even concern themselves with analysis of living conditions, showing the social service worker how to approach her work from a new angle, suggesting neighborhood or municipal organizations with which she might work, with a view to getting down to the cause of malnutrition, whether it be inadequate wages, unventilated tenements or what not.

The problem, the plan and the results will vary with individual hospitals, but it may well be that one day a dietitian will relegate her daily work to an associate, while she is called to testify before state or federal courts

as to the cause of undernourishment, the community responsibility therefor and state and national laws for bringing about a solution!

The Dietitian and the Teacher

Referring to the period when "teaching" meant only classroom work we rejoice in the realization that the hospital dietitian is now counted as a "teacher" in the highest sense of that noble word. We know that to "handle" untaught "help" is teaching; that to fit one's own department into the larger scheme of organization is teaching; that to train one's own assistants is assuredly teaching! Besides all of this, the dietitian of today is usually given the opportunity of teaching pupil nurses, not to mention interns; but that is another story.

It is with the old-fashioned use of the word teacher, however, that we are at present concerned, that is, as it is applied to the leader of activities in the classroom.

"But," protests some busy dietitian, "we certainly have no legitimate contact there; our field and the field of the classroom are far apart."

Are they? Let us suppose a case. The classroom teacher, let us say, has been a patient in the very hospital where the dietitian carries on her labors; during convalescence the two have a chat. As both are home economics women they find many common interests and it will be surprising indeed if the dietitian, from her background of original work with actual flesh and blood children, is not able to suggest to the teacher new ways of vitalizing her classroom work in nutrition.

Conversely, the teacher, speaking from *her* vantage ground, where systematic, analytical work in pedagogy prevails as a matter of routine, will almost certainly find herself in a position where she, in turn, can pass on to the dietitian helpful suggestions about presenting material to pupil nurses and other groups who may sit under the dietitian's instruction. Furthermore, data gathered in the course of the dietitian's work may easily prove of great value in formulating new courses of study for the classroom.

To train oneself to think in relationships and inter-relationships, rather than solely along the exclusive lines of the specialist is to increase one's powers of service many fold. Translate the results of work in one division of home economics into the terminology of kindred and parallel groups and that work enriches many groups instead of one.

The Dietitian and the Technician

The relationship between the dietitian and the technician is perhaps the most obvious and easily understood of all.

The dietitian turns instinctively to the results of the technician's work when she seeks the enrichment of her own store of knowledge; does she always realize that in the carrying out of the dictates of the laboratory and of checking their results, her own work may be of equal value to the technician?

Some years since when the writer was acting as visiting dietitian for the New York Association for Improving the Condition of the Poor, she remarked to her then and present guide, philosopher and friend, Henry C. Sherman, "It may seem presumptuous on my part but I am not sure that I always agree with you as to the use of potatoes in diets for the undernourished. Valuable as are potatoes, my families so often use them to excess, because, as one woman put it, 'they fill you so.'"

Whereupon, Dr. Sherman, proving still further his

right to the title of authority, replied genially: "O, that's all right! In fact I am glad to hear any results of your observations, because, you see, my workshop is only the chemical laboratory of the university, whereas you have access to numerous laboratories of even greater significance, that is, the human stomachs of your families!"

So, to return to our hospital dietitian, the patients with whose diets she is concerned may furnish data that will prove of inestimable value to the technician.

During a recent conference of city supervisors of home economics, Dr. Minna K. Denton of the U. S. Department of Agriculture said: "Yesterday 'home economics' meant cooking and sewing, today the words stand for health, tomorrow they will probably suggest cooperation in world affairs."

The hospital dietitian long since emerged from the cooking and sewing stage; she is today in the center of preventive and remedial work in health. Who shall say that she will not be in the forefront of the ranks of those

who "tomorrow are to be cooperating in world advancement?"

Not that the busy hospital worker will have either the time or the inclination to be consciously occupied with the various activities as outlined in this paper; her daily duties are too arduous for that, but experience seems to prove that in the workaday world, as well as in the world of the spirit, the unconscious influence wielded by an individual is fully as potent as that which is exerted deliberately.

Thinking in world terms was one lesson taught by the great war, thinking in professional terms is one of our responsibilities as home economics women.

The hospital dietitian who visualizes her job as one unit in the social fabric will find herself seeking and discovering more and yet more opportunities for making worthwhile contacts and for building worthwhile projects in cooperative endeavor.

HOW TWENTY-SIX DIABETIC PATIENTS ARE FED AT CHASE DIET SANITARIUM

BY MILDRED CHASE COOKE, CHASE DIET SANITARIUM, LOS ANGELES, CAL.

FOR several years, my work has been largely that of feeding diabetic patients. In this institution which takes care of thirty patients, I have often had from sixteen to twenty-six diabetic diets to supervise and, as a matter of necessity, have worked out many short cuts which enable my assistant dietitians to do their work easily.

I use the percentage grouping as suggested by Joslin. The first consideration in my planning of a diet is to keep the ratio of glucose and fatty acid the same for each meal as the prescribed diet makes it for the day. Thus a diet order which comes to me as carbohydrate 50, protein 40, fat 120 with a ratio of glucose and fatty acid content of approximately 1 gr. glucose to 1.5 gr. fatty acid, is divided so that in each meal glucose and fatty acid content is 1: to 1.5.

Insulin Given Twice a Day

The second consideration is that, since insulin in our house is given twice a day, (before breakfast and before supper) the glucose content is kept ten grams higher at those two meals than at dinner. The third consideration is that, since I make every effort to keep the diet as nearly like normal as it is possible with the necessary restrictions, I keep the protein content at dinner (which is at noon) much higher than at breakfast and supper, still maintaining the same ratio of glucose and fatty acid. Thus a diet of carbohydrate 50, protein 40, fat 120., is divided as follows:

	Carbohydrate	Protein	Fat
Breakfast	20	12	44.5
Dinner	10	16	31.
Supper	20	12	44.5

The physicians with whom I work feel that balancing of each meal is a decided factor in the building up of the patient's tolerance. I have a chart above my desk which I have worked out to aid me in the planning of any diet, without having to reduce it to the glucose and fatty acid value. The table appears in the next column.

Example: A diet order which comes to me as carbohydrate 160, protein 80, fat 190 is divided thus:

	Carbohydrate	Protein	Fat
Breakfast	64	24	70.5
Dinner	32	32	48.
Supper	64	24	70.5

TABLE USED FOR BALANCING MEALS FOR DIABETICS IN THE CHASE DIET SANITARIUM, LOS ANGELES, CAL.

CARBOHYDRATE				FAT			
Grams Ordered	Break.	Dinner	Supper	Grams Ordered	Break.	Dinner	Supper
30	12	6	12	55	16.5	22	18.5
35	14	7	14	60	18	24	18
40	16	8	16	65	19.5	26	19.5
45	18	9	18	70	21	28	21
50	20	10	20	75	22	30	22.5
55	22	11	22	80	24	32	24
60	24	12	24	85	25.5	34	25.5
65	26	13	26	90	27	36	27
70	28	14	28				
75	30	15	30	FAT			
80	32	16	32	Grams Ordered	Break.	Dinner	Supper
85	34	17	34	50	18.5	13	18.5
90	36	18	36	55	20	15	20
95	38	19	38	60	22	16	22
100	40	20	40	65	24	17	24
105	42	21	42	70	26	18	26
110	44	22	44	75	28	19	28
115	46	23	46	80	30	20	30
120	48	24	48	85	31.5	22	31.5
125	50	25	50	90	33.5	23	33.5
130	52	26	52	95	35	25	35
135	54	27	54	100	37	26	37
140	56	28	56	105	39	27	39
145	58	29	58	110	41	28	41
150	60	30	60	115	43	29	43
155	62	31	62	120	44.5	31	44.5
160	64	32	64	125	46.5	32	46.5
165	66	33	66	130	48	34	48
170	68	34	68	135	50	35	50
175	70	35	70	140	52	36	52
180	72	36	72	145	54	37	54
185	74	37	74	150	56	38	56
PROTEIN				155	57.5	39	57.5
Grams Ordered	Break.	Dinner	Supper	160	60	40	60
20	6	8	6	165	61.5	42	61.5
25	7.5	10	7.5	170	63	43	63
30	9	12	9	175	65	44	65
35	10.5	14	10.5	180	67	46	67
40	12	16	12	185	69	47	69
45	13.5	18	13.5	190	70.5	48	70.5
50	15	20	15	195	72.5	49	72.5
				200	74.5	50	74.5
				205	76	53	76

I use a "skeleton diet" for each diet of carbohydrate 50, protein 40, fat 120 or more, making the practical handling of the diet as easy as possible for my assistants.

The butter cutter is set so that each slice of butter weighs ten grams and each diet is planned so that the butter is used in such amounts that either whole slices, halves or quarters of slices are used, thus making weigh-

ing unnecessary. The bread is cut from standard loaves, each slice weighing thirty grams. The cream is measured in a medicine glass marked in red, and two ounces put into each pitcher. Vegetables are weighed in 100 gram lots, whether raw or cooked vegetables. Mayonnaise, when used is given in definite weights, fourteen grams at lunch, twenty grams at supper, thus the dietitians make a certain number of salads, all weighing the same, those with dressing having the same amount of dressing on them, no mayonnaise being given until the diet is high enough in fat value to allow the use of fourteen grams dressing at dinner, or twenty grams at supper. Ice cream is served at the noon meal, each serving being made of forty-five grams of cream mixed with fifteen grams water, flavoring and saccharine. This is simple to make and is a great favorite with the patients.

Every diet of C. 50, P. 40, F. 120 or more is planned on the following "skeleton diet."

Breakfast:

	Carbo.	Pro.	Fat
120 grms. 20% cream	4	4	24
15 grms. cereal (weighed dry) ..	10	2.5	1
3 cipher bran wafers			
Coffee			

This skeleton diet for breakfast figures: Carbohydrate 14, protein 6.5, fat 25. The remaining carbohydrate value, if less than nine grams is given as 5 per cent or 10 per cent fruit, if nine grams is given, as one-half slice bread, if more than nine grams is given, as bread and fruit, to make the carbohydrate total properly. If bread is used, the protein content is added to the protein of the skeleton. If the remaining protein needed is less than six, that column is totaled with the use of a crisp bacon, if it is six, it is totaled by the use of egg, if more than six grams, egg and bacon is used, if twelve grams two eggs are used. If the diet is low in fat and high in protein, egg white is used in place of bacon or the second egg. The fat column is totaled by the use of butter, using a quarter, a half, three quarters of a slice or a whole slice, to add the required amount. Sometimes it is difficult to make the fat come out exactly, but it can be done usually within one gram, for which I allow during the day.

At dinner the skeleton is as follows:

100 grms. 5% salad vegetable
100 grms. 5% cooked vegetable
60 grms. ice cream (recipe already given)
1 cup broth
3 cipher bran wafers.

The total value of the skeleton diet at dinner is: Carbohydrate 7.5, protein, 4.5, fat 9. The carbohydrate column is totaled by the addition of 5 per cent or 10 per cent fruit, if the necessary carbohydrate is less than nine grams, if nine grams, it is used as bread, if more than nine, is used as bread and fruit. The protein is used in the form of meat, the fat is totaled with butter, if less than fourteen grams is needed, if fourteen grams or more is needed, as mayonnaise or as mayonnaise and butter.

At supper everyone is given:

60 grms. 20% cream
15 grms. cereal (measured dry)
100 grms. 5% vegetable, uncooked
100 grms. 10% cooked vegetable
1 cup broth
Cipher bran wafers.

The carbohydrate column is totaled as in the other two meals,—with fruit or with bread and fruit. The protein is totaled with meat or egg or crisp bacon. The fat is totaled with butter, or with twenty grams of mayonnaise and butter. In cases of very high fat, I use 40 per cent

cream instead of 20 per cent, the usual amount.

One of the most valuable things I have learned is to make every tray at any one meal as much like every other tray as I can, making the weighing of individual portions as light as possible. You will see that with this plan, the only things that need to be weighed out especially for certain trays are, at breakfast, fruit and bacon (if the tray happens to have bacon on it); at dinner, meat and fruit; at supper, meat or bacon and fruit—everything else is all ready to use, in standard amounts. This makes the packing of the trays very easy and the service rapid.

As I sit at my table in the diet kitchen, my orders to my assistants run something like this:

Breakfast. No. 14 please. Check: 2 pitchers cream, 2½ slices butter, 1 dish cereal, 3 cipher wafers, 1 egg, fruit marked 14, coffee.

Dinner. No. 14. Check: 1½ slices butter, 2 half slices bread; meat marked 14; 1 salad with mayonnaise, 1 cooked 5% vegetable; 1 dish ice cream, 1 cup broth, 3 cipher wafers.

Supper. No. 14. Check: 1 pitcher cream, 1½ slices butter, ½ slice bread, 1 dish cereal, 1 salad with mayonnaise, 1 cooked 5% vegetable, meat marked 14, fruit marked 14, 1 cup broth, cipher wafers.

Thus, with very little trouble, no confusion and very few mistakes, our twenty-six trays leave the kitchen.

NEWS ITEMS

Miss Anthos Nesbitt has recently accepted a position at St. Luke's Hospital, New York, N. Y., as administrative dietitian in charge of the main kitchen. Since graduating from the University of Toronto, Miss Nesbitt has been dietitian at Mount Sinai Hospital, Philadelphia, Pa., and at the Hebrew Hospital, Baltimore, Md.

Miss Lucille Nusbaum is in charge of the diet kitchen and instructor in dietetics at Long Island College Hospital, Brooklyn, N. Y. She was formerly teaching dietitian at Mount Sinai Hospital, New York, N. Y.

Miss Dorothy Sayre completed a course in student dietitian training at Fifth Avenue Hospital, New York, N. Y., and has been appointed dietitian at the Norwich Memorial Hospital, Norwich, N. Y. Miss Sayre is a graduate of Mechanics Institute, Rochester, N. Y.

Miss Beulah Jones has resigned as assistant dietitian, Clifton Springs Sanitarium, Clifton Springs, N. Y., and will spend the summer at her home in Iowa.

The Dietitians Association of Philadelphia held an informal tea March 18, 1924, at the Business and Professional Women's Club. Senior students of Temple University, Drexel Institute and Beechwood were the guests. Mrs. Roper, social service dietitian, was hostess.

EXHIBIT ON NUTRITIONAL MATERIALS

A permanent exhibit on available nutritional material in Boston has been brought about through the efforts of the Massachusetts Dietetic Association. The exhibit gives in convenient form for public and professional use the centers of study and the particular type of work for which facilities are offered.

A NATURAL TIMEPIECE

"Mummy, is it my lunch time yet?"

"No, darling, not for another hour."

"Well, then, my tummy must be fast."—*Passing Show* (London.)

DISPENSARIES AND OUT-PATIENT DEPARTMENTS

Conducted by MICHAEL M. DAVIS, JR., Ph.D., Executive Secretary, Committee on Dispensary Development, United Hospital Fund of New York, 15 W. 43rd Street, New York
and by ALEC N. THOMSON, M.D., Director of Medical Activities, American Social Hygiene Association
370 Seventh Avenue, New York

CLINIC SERVICE BY APPOINTMENT

By JANET THORNTON, COMMITTEE ON DISPENSARY DEVELOPMENT, UNITED HOSPITAL FUND, NEW YORK, N. Y.

FOR many years, strong pressure has been felt for an adequate and economical system of clinic management. This has been produced by three factors; first, the increase and concentration of populations in industrial centers and the consequent increase in need and demand for clinic service; second, changes in the practice of medicine entailing more service both in quantity and kind, and third, changes in popular concepts of health, resulting in the seeking for medical help earlier and oftener.

The physician's private office has been under a similar pressure and has been more sensitive than the clinic to the economic aspect of high rentals, large waiting rooms, and up-to-date equipment. For some time, therefore, many doctors have seen patients in their offices by appointments as to day and hour, and have so arranged their affairs that there should be a steady regulated flow of patients to bring about the full utilization of office hours when the doctor is there.

The individual patient likewise is forced by the economic pressure of modern industrial life to save his time. To have to spend half a day to get treatment for some minor ailment makes the cost of such treatment practically prohibitive, no matter how much he may realize its value. An appointment largely remedies this.

Economic pressure is more slowly perceived in institutions supported by charitable funds which are generally tax- and rent-free, but whenever the institution has realized the fast growing demands from the community for more medical service, and service more complex and costly, a great normal pressure begins and gradually compels the development of system, of efficiency, of economy, in brief, of more adequate service without undue expenditure of funds.

This type of development does not "just happen." Jobs must be studied and defined, people must be selected and trained to do them. Research is needed, and the recognition of the essential importance of many activities usually deemed negligible. This is the lesson of scientific management developed by Taylor and others.

Distribution of Patients

For the dispensary an important feature is the distribution of the arrival of patients over given periods. A brief discussion of certain items for carrying out this distribution, its relations with other features of management and its cost, may be useful to readers of THE MODERN HOSPITAL.

It is a dozen years or more now since clinics began to assign, orally, dates for the return of their patients. The children's clinic of the Boston Dispensary went a step further about eight years ago and arranged that each doctor give his patient a slip to remind him when to return. The slip also bore numerous wise health messages for the child's enlightenment. Clinics likewise have kept records of the appointments on index cards which were filed under the expected date of return. Except in some clinics where it is necessary to provide ahead of time for certain fixed amounts of perishable drugs and other materials, there has not been known to the writer any attempt to regulate the numbers admitted in accordance with the clinic's capacity for service.

Furthermore, although patients may have been told to present themselves at a certain hour, the clinic has not generally felt the obligation to serve them at that hour. The time patients wait idly, even in the better managed clinics, usually runs from one to three hours.

First Appointment Systems

Service by an appointment system similar to that in private offices was offered for the first time in this country in October, 1921 by the children's clinic of the New Haven Dispensary. In November, 1921 Cornell University opened its reorganized and much enlarged clinic, embodying several radical conceptions; namely, that service be at cost; that doctors be paid; that the patients be selected on the basis of economic grading; that histories containing all medical and social information about patients be kept as units and filed in a central record department; that attendance be regulated by estimated capacity; and that direction of treatment of any case be under the control of a single clinic.

Realization of these conceptions necessitates scientific management. An obviously important feature of such management is the distribution of the arrival of patients over given periods, regulating the number admitted by the available service, space and time.

In July, 1922 the out-patient department, of the Presbyterian Hospital, New York, N. Y., reorganized its admission system on an appointment basis, and about a year later the Johns Hopkins children's clinic adopted a similar scheme. More recently the Children's Hospital, Boston, Mass., has undertaken the experiment.

THE MODERN HOSPITAL for July, 1923 contained a valuable description of the appointment system in the children's clinic of the New Haven Dispensary, by Dr. Ethel

C. Dunham. The worst effects of the old clinic plan, according to Dr. Dunham are:

(1) The acceptance of all applicants who arrive within given hours regardless of the number of physicians or the time available to care for them. By this system many are hastily and carelessly treated, and some, after long waiting, are sent away disappointed and not treated at all.

(2) Long waiting at a clinic entails loss of earnings and domestic inconveniences on a group in the community least able to afford them, while the tedium of long waiting discourages the patient's interest and militates against his cooperation.

(3) Uneven distribution of work for the physicians makes one day too heavy and another too light.

(4) Crowding people for long periods in waiting rooms, ill-lighted and poorly ventilated, increases the hazards of exposure to disease.

One is tempted to extend the list of defects.

(5) The misuse of floor space for unnecessary waiting room in our congested industrial communities is a matter for public concern.

(6) The execution of poorly understood procedures in the stiff military manner of many hospitals has a demoralizing effect on doormen, clerks and assistants and other employees.

(7) The noise and confusion of restless crowds and the resulting tendency toward rudeness and unfriendliness on the part of the institution's employees, prevent many in the community who need it from seeking the clinic's care.

(8) The conditions enumerated tend to lower the self-esteem of those who do seek the care. They increase their discomfort and may increase the disability.

(9) Patients see different doctors from visit to visit and may be given conflicting opinions and recommendations, thus being deprived of a most potent therapeutic influence, the understanding of and confidence in the personality of the physician who follows their condition.

In short, the failure to study and plan scientifically for the management of clinics discourages professional service as well as the cooperation of patients and in great measure frustrates the very object for which the clinic is supported.

Improvements With Appointment System

Dr. Dunham describes some improvements brought about by the appointment system in the New Haven Dispensary (and it may be noted here that earnest and intelligent effort to improve any one clinic procedure tends to affect many associated procedures, since all functions of a hospital are closely inter-related):

(1) The clinic is open to receive applications for appointment from 9 a. m. to 5 p. m., instead of from 9 to 10 a. m., and applicants not admitted on their first approach are not just told to come earlier next time.

(2) Unnecessary visits due to planless care by physicians are discouraged.

(3) The physicians are enabled to have time for adequate study of patients.

(4) Patients can be brought back for special classes, or demonstration such as for medical teaching or consultation.

(5) The interchange of service between hospital and outside social agencies becomes mutually more satisfactory and effective.

(6) Similarly, the private physicians outside are helped to give better care to the public by having a well-organized clinic group to consult.

(7) An appointment system implies regulating the number of cases accepted by the known provision of staff, space, and equipment.

(8) Further improvements resulting from the use of an appointment system are the great economy of space and the fuller and more even utilization of equipment, the regulating and stabilizing of every phase of clinic activity in x-ray department, laboratory, record room and pharmacy, at the admission desk and in the separate clinic divisions.

(9) Again, more patients may be cared for by the same staff in the same rooms, during the same hours. Thus, in one institution, there were about 1,000 more visits and 250 more new patients a month accommodated after the appointment system became established.

(10) Patients referred to other clinic departments or to laboratories for joint study and treatment secure these far more frequently under an appointment system mainly because real planning for the appointments prescribed means taking thought for the convenience and welfare of the patient and securing as much as possible for him in one visit without overtaxing him.

The advantages cited, if longer trial proves them permanent, have immediate value in meeting the problem which today faces the trustees of the hospitals, that of supplying clinic service to larger numbers of people, and at the same time modifying and intensifying this service to meet the requirements of modern medical practice that each patient be studied and treated as an individual.

Sharper definition of purpose, detailed estimate of service resources, and business-like operation are major motives of modern hospital organizers. Those who would install an appointment system will find that they must reckon with those motives, for at the very outset they

will be called upon to decide who and how many of the applicants will be accepted, and to design and execute adequate procedures for handling those accepted.

Procedures for receiving applicants are being widely studied in various institutions following somewhat different paths of investigation. Several are testing out the procedures for admitting patients by appointment, and though the period of experimental operation is not yet ended a few requisites generally agreed upon may be given.

First of these is the interest and help of the physicians in the clinic, since the underlying strength of the system consists in planning for each case. The patient should have at least a dim image of the goal a physician sets for him to reach and at the very least should be informed about the next step he is expected to take. Second, some clerical service is a requisite, its extent dependent on the size and character of the clinic. Third, record forms and filing devices are necessary for smooth and sure operation.

Hardly more than a beginning has been made in analyzing and standardizing the processes of clinic management and until that has been accomplished it is not possible to say how much clerical or other service is necessary for any particular operation, such as running by appointment. Today each establishment must make its own guess, at the same time seeing to it that performances create standards for the future.

That an appointment system, like all other human inventions, will not run of itself, that when in action it influences all other activities of the clinic, that it is not a panacea for all the ills of clinic management, so far one may safely dogmatize.

Forms and Devices

What forms and devices have been found useful? Here one is on a little firmer ground. Two kinds of records there must be: something to remind the clinic that the patient is due on a day and hour; something to remind the patient that the clinic expects him. Some clinics enter the date and hour of the appointment on the reverse of the identification card, some on an extra slip. The two-in-one combination of the first is convenient, because it displays in one place all appointments the patient has made for a given day.

The extra slip method, by means of carbon, yields a duplicate to serve as the clinic reminder of the appointment. The duplicate can also be used in summoning the history from a central file and be held as a voucher in the file until the history is returned. But the extra slip method does not display the day's work of the clinic.

When running on schedule, time is important. Because of this a sheet displaying the distribution of appointments over any one day will be necessary. Any stationer's diary of suitable size can be used by marking off the appropriate time intervals on any given day. These will vary from five to fifteen minutes, or half an hour, depending mainly on the character of the medical work. Thus, in a medical department treating diabetes or gastro-enteric cases, three-quarters of an hour may be necessary for a new patient, and fifteen minutes for an old. In such a clinic it is well to divide the session time into units of fifteen minutes each and arbitrarily assign the requisite blocks of units according to the case. In some other type of clinic, such as otology, a five-minute unit might be sufficient, allowing two units for an old, and three for a new patient. In any given clinic the doctors must work out on the basis of their own experience the

length of the unit and the relation between old and new.

When approximate time units per case have been worked out according to the type of medical care, it has been found more satisfactory to have special schedule sheets printed and held in a loose leaf notebook.

Whether each doctor keeps his own book or has the assistance of an aide, whether one book is kept by an aide for a team of doctors, assigning each member of the team a column, is determined by the special character of the clinic, the size and the peculiar local conditions to be met.

It may be found convenient to use the same device for recording other clinic procedures. On the loose leaf diary page such statistical items as attendance, new and old patients, kept and broken appointments, or time per case, may be entered. An index card for each patient registered in the clinic is an old device for recording appointments and other data often used satisfactorily in small clinics. However, it is too individualistic to be safe where a group must use the same file of cards.

At the present time clinic workers who are thoughtfully studying and testing appointment methods are unwilling to recommend either set of procedures or devices. They desire to have many different institutions discover their own needs and measures of relief. Valuable results to clinic practice appear to accompany successful operation of an appointment system, however technically managed, making doctors more definite about return dates and all other instruction, as well as about writing these items into their histories.

It has been found that the treatment of ambulatory surgical conditions is completed in less time, with fewer visits, and medical conditions requiring continued treatment are kept longer under supervision.

What is it worth to secure such results? And what does it cost in dollars and cents to operate the system? Perhaps some day patients and scientists will answer.

For what little light they may throw on the cost question the following figures are cited. They should not be taken as more than approximations, since it is difficult to disentangle the process of assigning appointments to patients from other concomitant and related processes. Further, it may be said that costs determined by isolating one process from its natural setting cannot be applicable to clinics where no general scheme for orderly serving of patients has been put into practice.

From several time studies made it would appear that in a large surgical clinic the non-medical assistants spent from 12 to 15 per cent of a three-hour session (roughly 25 minutes each) in assigning appointments for return visits to some forty or fifty patients. The surgeons gave no time beyond that required to dictate the return date for the histories.

In several medical clinics the time varies between ten per cent and twenty per cent. In one of the clinics where each doctor enters appointment dates in his own diary as well as on the patient's card, the average time per case is forty seconds, and each doctor takes some ten cases a session. In this clinic then about five per cent of the physician's time must be credited to the appointment work, but as physicians are usually not paid this time has not been counted.

About one-eighth of secretarial time seems a sufficient allowance, leaving seven-eighths for other clinic services.

Cost, then, is not a factor of great importance. Yet to conclude therefrom that every clinic might forthwith and without difficulty install the appointment plan of admission would be underestimating the task. Until the institution itself recognizes the need for more effective meth-

ods of management; until the medical staff in particular, not only recognize the need, but test out methods to meet it, little good can come from the attempt to enforce certain isolated bits of management. Adopting an appointment slip, for example, without modifying essentially related processes of an old clinic is not worth while.

Hospital organizers will do well in this regard to ponder the early experience of management engineers in industry. Broad general principles apply to all establishments. The embodiment of these principles and the functioning is always somewhat different for different establishments. Most hospitals, if they can once adjust themselves to the thought that they are not already perfect, can find the motive power and the intelligent direction within themselves to reshape their purposes and mode of operation to fulfill the requirements of modern medicine.

MARINE HOSPITALS TRIPLE SERVICE IN LAST DECADE

Three times as many patients receive treatment in the U. S. marine hospitals today as in 1913, according to the statement recently made by Surgeon General Hugh S. Cumming. Statistics show that the cost of maintenance has also doubled in the last decade.

The per diem cost of service per patient in 1923 was \$4.08 which sum includes all salaries of surgeons, attendants, light, heat, power, repairs to buildings, and such items. Statistics published by the Bureau of Labor show that the price level of major necessities averaged 70 per cent higher than in 1913. Improved standards of living including increased wages of personnel have made for increased operating expenses. The employment of trained female nurses also adds approximately \$500,000 annually to the operating costs of marine hospitals.

NATIONAL HOSPITAL DAY AT GRANT COUNTY HOSPITAL

A crowd estimated at between 350 and 400 visited the Grant County Hospital, Marion, Ind., May 12. A feature of the day was a baby show in which forty-five babies were entered for health points and for which prizes were given the three babies with the highest number of points.

The show attracted much interest. The babies were divided into three classes, 6 months old class, 12 months class and a class from 1 to 2 years.

The prizes awarded were \$2.50 in gold for the 6 months class, \$5 for the 1 year class, and \$5 for the 1 to 2 year class.

The judges for the show were Dr. W. A. Fankboner, Dr. Nettie Powell and Mrs. Herman Herzog, all of Marion.

From 2 to 5 o'clock in the afternoon tea was served by members of the ladies auxiliary of the hospital.

Demonstrations in the nursing care of the sick were put on by the student nurses of the hospital for the benefit of a number of classes from the Marion High School.

ADOPTS APPOINTMENT SYSTEM

The New York Nursery and Child's Hospital, New York, N. Y., has just inaugurated the appointment system in the children's clinics to eliminate the long waits which mothers and children formerly experienced and to enable the former to devote that time to their domestic duties. The appointment system also enables the doctors to see a larger number of patients each day and to devote more time to each than was possible under the old system.

OCCUPATIONAL THERAPY AND REHABILITATION

Conducted by LOUIS J. HAAS, Director of Men's Therapeutic Occupations, Bloomingdale Hospital, White Plains, N. Y., and
MRS. CARL HENRY DAVIS, Advisor in Occupational Therapy, 825 Lake Drive, Milwaukee, Wis.

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VOLUNTARY SUPPORT FOR FEDERAL AND STATE REHABILITATION SERVICE

BY R. C. BRANION, EXECUTIVE SECRETARY, NATIONAL COMMITTEE FOR THE DISABLED, NEW YORK, N. Y.

UP TO this time there has been no voluntary agency, national in scope, interested in the vocational rehabilitation of persons disabled in industry or otherwise. A new organization known as the National Committee for the Disabled has been created to meet this need. The national committee has as its purpose the development and direction of a nation-wide interest in the welfare of the disabled. In the March issue of *THE MODERN HOSPITAL*, p. 310, Mr. John Aubel Kratz of the Federal Board for Vocational Education drew a comprehensive picture of the problem of the disabled in the United States, and of the splendid steps being taken by the federal and state governments in the field of vocational rehabilitation.

Help of Private Agencies Needed

The casual reader of that article, who has not firsthand knowledge of the problem may hastily assume that since official action is being taken to deal with the handicapped, there is less need for action on the part of private agencies, at least in those states cooperating with the federal government. As one reviews the facts disclosed by Mr. Kratz, it becomes evident that the very nature of the problem demands for its solution more complete popular understanding and wholehearted cooperation of voluntary agencies in all communities. As Mr. Kratz indicated, the thirty-six states cooperating with the federal government rehabilitated 3,530 individuals suffering various handicaps during the year ending June 30, 1923. On that date also there were 15,515 other disabled persons enrolled for rehabilitation service. Compared to the number of individual cases served by some hospitals or other voluntary agencies, these figures seem relatively small. Likewise, approximately 84,000, the total number of disabled persons who each year require rehabilitation service, does not impress one as large.

As we analyze the steps which must be taken by the rehabilitation agencies, it becomes apparent that the amount of effort expended in dealing with these cases is tremendous. Unlike the hospital to which patients are referred for institutional treatment, the state rehabilitation agency is a field organization whose services must reach out into the smallest town and into the very homes of the handicapped. It serves persons who are disabled through industrial accident, public accident, permanently

crippling disease or congenital conditions. Such persons may be found in practically every community. Some come to the attention of the rehabilitation agency soon after an accident. Others who have been disabled for years are reported as soon as they have completed grammar school education and become eligible for state assistance. Still others come from institutions or their homes where, for lack of rehabilitation service, they have been dependent upon their families or the public for support. Literally thousands of cases reported must be reviewed and intelligently studied as to eligibility and feasibility for vocational rehabilitation.

Allied Problems to Be Adjusted

Intelligent decision in each case presupposes a survey covering the individual's previous training, social and economic status, his aptitudes and desires, as well as his physical condition. In many cases before the program of the rehabilitationist may be undertaken, a disabled person must be referred to the proper authorities for further medical, surgical or therapeutic treatment. In numerous cases problems involving compensation must be adjusted and in some cases arrangements must be made for maintenance of the individual and even of his family during the period of training. Frequently a prosthetic appliance is required and in those states whose laws do not permit the purchase of such appliances from state funds, arrangements must be made to secure financial assistance from relatives, friends or voluntary agencies. Once these steps have been taken and the way is clear for vocational rehabilitation, the decision must be made as to the type of service the individual requires.

Individual Training Program Called for

In planning for the course of training and deciding how the training should be provided, the worker must take into account the age and other individual characteristics of the person to be trained. If the training is to be provided in a trade or commercial school, care must be exercised in the selection of the school as well as the course, and a definite training program, individual in character, must be arranged. If training is to be provided on the job, an employer in the right industry and of the type who will give the necessary supervision and instruction must be sought out. Not infrequently, the type of training and

the type of job selected must depend not only upon the individual's permanent physical handicap but likewise upon complicating physical weaknesses which make especially favorable working conditions necessary. Industries throughout the territory must be carefully surveyed with the handicapped person in mind. It is readily seen therefore that the problem involves intensive case work on behalf of individuals scattered over an extensive area. Every case may entail contact with the man's family, his friends, physician, hospital, previous employer, prospective employers, social service agencies, training schools, civic bodies and various state departments.

When the problem is reviewed in this way and it is noted that the service staffs of the thirty-six states cooperating with the federal board do not exceed a total of 150 persons, it is obvious that the burden of responsibility for rehabilitation service must rest upon social service agencies, medical agencies, civic bodies and employers with the state rehabilitation agency as a coordinating force. This was early recognized by the Ohio state department which developed a plan providing supplementary service in all counties of the state. An analysis of the distribution of the cases served during 1923 disclosed that they were widely distributed and were found in practically every county of the state.

Ohio Plan and Community Activity

The Ohio plan calls for the establishment in each community of a clearing agency, representative of the various groups concerned, with an advisory committee including in its membership leading educators, a physician, a nurse, a home visitor, employment managers thoroughly acquainted with local industrial conditions and employment possibilities. The state of Ohio is among the leaders in the development of rehabilitation service. It is important to note that Mr. M. B. Perrin, supervisor of civilian rehabilitation service for the state of Ohio, believes that their progress is almost wholly due to the splendid relations which have existed between the state officials and the local people.

In other states and especially in some of the larger cities, cooperative relations have been developed to greater or less degree. The situation would seem to call for a definite plan in all states. It should be a matter of deep concern to leaders in social service and medical social work to see that relations of this sort are developed between the state rehabilitation service and the local people in all of the states.

Nation-wide Interest in Disabled

As stated previously in this article, it is the purpose of the National Committee for the Disabled to develop a nation-wide interest in the welfare of the disabled and direct this interest into the channels of effort which experience indicates are most likely to succeed. The National Committee is an outgrowth of the Institute for Crippled and Disabled Men which has been conducting research work and pioneering in this field during the past six years.

The National Committee membership is to be representative of the entire country. Its program includes the promotion of widespread understanding of the problem of the disabled and possibilities of rehabilitation. It aims to serve as a clearing house for information on this subject, and to assist in making the rehabilitation service of the federal government and the states more effective through the development of a deeper interest in the problem on the part of the general public, employers and agencies whose general service, whether social or medical,

brings them in contact with the physically disabled. It proposes to assist in the study of local situations and recommends plans for adequate programs under local auspices.

Thorough study will be made of legislation now operative and steps taken looking toward the enactment of such further legislation as from time to time may prove desirable.

Headquarters for the committee have been established at 245 East 23rd Street, New York City.

The budget for the first two years of work of the national committee is assured through the generous support of the Commonwealth Fund, the Laura Spelman Rockefeller Memorial and the trustees of the Institute for Crippled and Disabled Men.

THE ROLL CALL

Since the publication of the last Roll Call, Arkansas, California, Connecticut, and Philadelphia have organized associations of occupational therapy. The formation of these new societies together with the increased memberships and enthusiasm for activity of the older associations indicate the gratifying growth and development of occupational therapy. A new school has also been started in Louisville, Ky. The following word has come from the associations and schools:

ASSOCIATIONS

Arkansas

The Arkansas State Occupational Therapy Association is quite active for so young an organization. The monthly meeting in March took the form of an informal dinner which made possible the presentation of constructive information to a large number of persons. The association decided to finance a paid educational secretary who will act as the local publicity agent for occupational therapy.

At the state convention of the federation of women's clubs held at Pine Bluff, resolutions were adopted requesting the University of Arkansas to include in the extension work a course in occupational therapy. It was further resolved that the federation promote and support the introduction of such a course of training.

California

Association organized.

Connecticut

A group of interested people including physicians, public health nurses, social service and Red Cross workers, mental hygienists, etc., met and appointed a committee to investigate and report on the state of occupational therapy in Connecticut, the apparent need for further development of the work in the state, and to prepare a plan of possible activities.

Illinois

Miss Frances Stewart has left Michael Reese and gone back to the Presbyterian Hospital, Chicago. Mrs. Olive Carey has taken charge of the occupational therapy department at Michael Reese Hospital, Chicago. Pauline Sharp has left Sarah Morris Memorial Hospital, Chicago. Bess Sutton was back in Chicago for a few weeks, and has taken a position temporarily in state work. Mr. Thomas Bessell Kidner was an overnight visitor in Chicago.
(Continued on page 604)

Prevention of Acidosis

—an Important Hospital Function

Since the hospital is primarily a public health agency, its function includes not only the diagnosis and treatment of the immediate disease or injury, but safeguarding against complications and teaching the patient simple fundamentals of health protection.

The service of any hospital group may properly include educational work toward the end of preventing acidosis since it is a forerunner of such serious organic troubles.

This condition resulting from ill balanced metabolism is frequently observed for the first time when the patient enters the hospital for diagnosis and treatment of some other ailment. Whatever may be the underlying cause the simple corrective treatment here discussed should be considered by those responsible for the treatment and care of patients in hospitals and similar institutions.

Gastric hyperacidity, acidity of the mouth and other of the more obvious manifestations of acidosis are promptly counteracted by Phillips' Milk of Magnesia which has a pronounced affinity for acids, the harmless resultant compounds being readily excreted.

The increasing use of sodium bicarbonate by the public to control "acid stomach" should be considered in this connection. Only a part of the bicarbonate is effective and that portion which produces carbon dioxide may be seriously detrimental.

Phillips' Milk of Magnesia being free from carbonates does not distend the stomach nor cause flatulence of the lower intestinal tract. Its antacid action is pronounced. A given quantity of Phillips' Milk of Magnesia neutralizes almost three times as much acid as a saturated solution of sodium bicarbonate and nearly fifty times as much as lime water. Further it has the additional merit of being laxative, a quality of importance here since constipation is so frequently the underlying cause of hyperacidity.

DOSAGE

The usual dose of Phillips' Milk of Magnesia, as an antacid, ranges from one teaspoonful (4 c. c.) to one tablespoonful (16 c. c.) This amount should be mixed with an equal portion of cold water or milk and given half an hour after meals.

For its laxative effect, the adult dose is one to two fluid ounces (30 to 60 c. c.) The aperient action may be facilitated by giving the juice of lemon, lime or orange, half an hour thereafter.

PHILLIPS' Milk of Magnesia

CAUTION. Beware of imitations of Phillips' Milk of Magnesia. The genuine product bears our registered trade-mark. Kindly prescribe in original 4-ounce (25c bottles) and 12-ounce (50c bottles) obtainable from druggists everywhere.

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When using advertisements see Classified Index, also refer to YEAR BOOK.

NEW YORK OCCUPATIONAL THERAPISTS HOLD FIRST ANNUAL INSTITUTE

THE first annual institute and conference of the chief occupational therapists of the New York state hospitals was held in the offices of the State Hospital Commission, 175 Fifth Ave., New York, N. Y., April 21 to 24. Discussions, talks and demonstrations filled the sessions of the four days. Chief occupational therapists from each of the thirteen state hospitals, members of the hospital commission, medical superintendents, representatives of the Boston and Philadelphia schools of occupational therapy, as well as a number of prominent occupational therapists from New York and several other states, attended the meetings.

Mrs. Eleanor Clarke Slagle, director of occupational therapy for the State of New York, who opened the conference, outlined the purposes of the institute and introduced Commissioner Harriet May Mills who welcomed the therapists to the first annual institute.

Program for Mental Patients

Following Miss Mill's address, Dr. C. Floyd Haviland, chairman, New York State Hospital Commission, spoke on the state rehabilitation program for mental patients outlining the commission's program for rehabilitation. He said this must be fitted into the hospital scheme along with other treatment measures, but made it quite clear that the commission considered occupational therapy the most important single means of treatment now available.

A chart analysis of occupational therapy activities at King's Park State Hospital was presented by Miss Harriet A. Robeson, chief occupational therapist, King's Park State Hospital, King's Park, L. I.

In response to a request from Mrs. Slagle, Dr. Marcus B. Heyman, superintendent, Manhattan State Hospital, Ward's Island, New York, Dr. Isham G. Harris, superintendent, Brooklyn State Hospital, Brooklyn, and Dr. Walter G. Ryon, superintendent, Hudson River State Hospital, Poughkeepsie, described the progress of occupational therapy in their respective hospitals, citing several interesting cases of individual and group improvement. Dr. Spencer L. Dawes, medical examiner, New York State Hospital Commission spoke on "The Alien Insane—the Problem of Deportation."

The afternoon of April 21 was given over to the following program:

"Some Features of Institutional Planning," by the Hon. Sullivan W. Jones, state architect, New York Hospital Commission.

"The Relation and Service of the State Charities Aid Association to the State Hospitals," by George A. Hastings, executive secretary, S.C.A.A.

"Vocational Training: Its Possibilities and Limitations in Hospitals," by Thomas B. Kidner, president, American Occupational Therapy Association, New York.

"The Relation of the Mental Health Clinics to the Individual Hospital," by Dr. Philip Smith, deputy medical inspector, New York State Hospital Commission, New York.

April 22, at 9:30 a. m. the members of the group left for White Plains, where they were the guests of Bloomingdale Hospital. There Mrs. Slagle spoke informally on her early observations of occupational therapy at Bloomingdale Hospital, and introduced the speakers of the day.

Dr. John R. Ross, medical inspector, New York State Hospital Commission, spoke on "Observations on the State-Wide Program of Occupational Therapy."

Dr. William L. Russell, medical director, Bloomingdale Hospital, addressed the institute upon the development of occupational therapy.

Delegates Visit Bloomingdale Hospital

Following luncheon, the members of the institute spent the afternoon inspecting the occupational departments for men and women patients, and the departments of physical education. Bloomingdale Hospital has special buildings for the men's and women's occupational therapy departments with a director and therapists in charge at each building. The physical education departments each have their own director and staff of assistants. The men's new gymnasium building has just been completed and plans have been prepared for a new building to house the women's physical education department.

The following program comprised the remainder of the institute.

April 23, 10 a. m.: Sessions at the Art Center, 65 E. 56th St., New York, N. Y.

A talk on the mechanism of looms, with illustrations of various types of looms, materials and product, was given jointly by Miss Beatrice Abbott and Miss Edith Snow. The entire morning was given to visiting this studio and the art centre exhibit galleries.

April 23d, 2 p. m.; Office of the Commission:

"Statistics in Occupational Therapy," by Horatio M. Pollock, Ph.D., statistician, State Hospital Commission.

Round table (a) Waste Material—Its Use and Abuse in Hospital Occupational Therapy Departments; discussed by Mrs. B. B. Tomkins, chief occupational therapist, Gowanda State Hospital, Gowanda, and Miss Helen Ryce, chief occupational therapist, Hudson River State Hospital, Poughkeepsie. (b) How may occupational therapists keep informed? How best develop their professional abilities? discussed by Mr. Louis J. Haas, director of men's therapeutic occupations, Bloomingdale Hospital, White Plains.

Books on Crafts; discussed by Miss Mary Marvin, chief occupational therapist Buffalo State Hospital, Buffalo.

Mrs. Slagle and the therapists attending the institute were entertained at dinner at the Waldorf Astoria Hotel, in the evening.

April 24—9:30 a. m.

Demonstration of projects by each chief occupational therapist.

Discussion: Miss Harriet A. Robeson, chief occupational therapist, King's Park State Hospital, King's Park, L. I.; Miss Minnie Libby, chief occupational therapist, Middletown State Hospital, Middletown; Miss Jessie Tozier, chief occupational therapist, Rochester State Hospital, Rochester, N. Y.

Round Table Discussion: The training of personnel for the hospital occupational therapy service in the hospital itself.

(a) Untrained personnel. Miss Belinda Wright, chief occupational therapist, Manhattan State Hospital, Ward's Island.

(b) The present training course for nurses; is it adequate? Miss Irene Cunningham, chief occupational therapist.

HEALTH-GIVING DIETS

FOR INVALIDS AND CONVALESCENTS

BECAUSE edible gelatine is a highly protective colloid which, in combination with other wholesome foods, materially aids the digestion, it is invaluable for invalids and convalescents, and because it has an unusually nutritive lysine content, it is of the utmost importance in the diet of growing children.

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For Acid Stomach and All Other Forms of Indigestion

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Gelatine with Raspberry Juice
Apricot Soufflé
Blanc Mange

For Rickets and Scurvy

Grape Juice Jelly
Pineapple Jelly
Lemon Jelly
Jellied Prunes
Strawberry Jelly
Tomato Juice with Gelatine

For Fever Patients

French Orange Jelly
Lemon Jelly
Strawberry Ice
Fruit Sherbet
Apricot Jelly

For Tuberculosis

Orange and Raw Egg Jelly
Spanish Cream
Orange Charlotte
Tomato Jelly
Jellied Chicken Bouillon

For Diabetes

(To be prepared with saccharine)

Grape Fruit Jelly
Jellied Vegetable Salad
Fruit Salad Suprême
Cranberry Frappé

For Underweight Children

Gelatine Spread for Bread
Cocoa Cream
Rice and Orange Jelly
French Dainties
Rhubarb Jelly

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For many infants who are unable to assimilate any milk formula, "gelatine-ized" milk has been found highly successful, prepared as follows: Soak one level tablespoonful of Knox Sparkling Gelatine in one-half cup of cold milk, from the baby's formula, for ten minutes; cover while soaking; then place the cup in boiling water, stirring until gelatine is fully dissolved; add this dissolved gelatine to the quart of cold milk or regular formula.

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We shall be glad to send you free, upon request, practical recipes for the foregoing and many other beneficial gelatine dishes, together with SCIENTIFIC REPORTS on the importance of plain edible gelatine in the dietary.

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pist, St. Lawrence State Hospital, Ogdensburg.

(c) Suggestions for questions pertaining to examination in occupational therapy for nurses in training. Miss Lois Schenck, chief occupational therapist, Willard State Hospital, Willard, N. Y.

(d) Self-Improvement Classes. Miss Mary Gold, chief occupational therapist, Binghamton State Hospital, Binghamton.

Resumé of the round table discussion, Miss Pauline Gundersen, director, women's occupational therapy department, Bloomingdale Hospital, White Plains.

April 24—1:30 p. m.

Recreational activities, parties, music, games.

Discussion: Miss Jessie Stark, chief occupational therapist, Utica State Hospital, Utica.

The physical education program, Miss Virginia Scullin, chief occupational therapist, Central Islip State Hospital, Central Islip.

Summing up of the institute's work, Mrs. Eleanor Clarke Slagle.

THE ROLL CALL

(Continued from page 600)

cago during the past month, and held several conferences which were a stimulation to Illinois workers.

The last regular meeting of the Illinois Society of Occupational Therapy was voted a great success by the members. Definite information about each department was given at the meeting. This included: (1) Cost per year and who provides funds; (2) number of workers; (3) number of patients last year; (4) number of days' treatment; (5) average number of patients per day; (6) hours on duty; (7) holidays and vacations; (8) records: how kept: disposal: who uses them: prescription blanks: etc.; (9) luncheon: laundry: full maintenance?; (10) volunteer workers? How managed?; (11) provision made for practice workers. A representative from each hospital spoke to the point, and comparisons were made as we went along, and a most helpful time was the general opinion voiced.

Mrs. Frederick Dale Wood, of Chicago, a member of the national board, was the official representative of the American Society of Occupational Therapists at the dinner given by the American Hospital Association to its president, president-elect and retiring president in the Hotel La Salle, Chicago, March 3.

Michigan

The Michigan association met at Newberry House, March 3. Mrs. Carlyle Smith, who has been in charge of the work for blind children conducted under the supervision of the state board of education, gave an interesting account of her work which, during the past three years, has grown from three departments to thirteen. Since the first of the year, two new departments have been organized in the state, one at the Traverse City State Hospital, Traverse City, under the direction of Miss Mary Block, the other at Newberry State Hospital, Newberry, under the direction of Miss Marian R. Medd, a graduate of the Kalamazoo State Hospital Training School, Kalamazoo.

Minnesota

The last meeting of the association was held at Asbury Hospital, Minneapolis, February 4, 1924. A paper was read by Dr. M. H. Tibbetts, orthopedic surgeon in Duluth, on "Occupational Therapy in Orthopedic Practice." Miss Beatrice Lindberg, director of occupational therapy for the advisory commission of the Minnesota Sanatorium for

Consumptives, gave an interesting talk on "Weaving" which she illustrated with many examples of weaving. Miss Louise Hinkley, U. S. Veterans' Hospital No. 65, St. Paul, gave a brief account of the national convention in Milwaukee. Dr. R. O. Beard of the medical school, University of Minnesota, Minneapolis, read and discussed the tentative plans of the course of study in occupational therapy which is to be offered as a four year course at the university. Miss Beatrice Hardy of the Mayo Clinic gave an account of the occupational therapy work done at Worrell, St. Mary's and the Colonial hospitals at Rochester. Miss Gladys Pattee of Asbury Hospital presented an exhibit of work done at the hospital.

In November last Miss Esther Macomber of U. S. Veterans Hospital No. 65, St. Paul, was transferred to Whipple Barracks, Prescott, Ariz. Miss Louis Hinkley was transferred from U. S. Veterans Hospital No. 78, North Little Rock, Ark., to U. S. Veterans' Hospital No. 65, St. Paul.

OCCUPATIONAL THERAPY SCHOOLS

Boston

Length of course—Twelve months; an optional four months hospital practice work is now offered.

Number of students—Twenty-one.

Louisville

Length of course—One year and a half.

Number of students—Five.

The Louisville School of Social Work was organized January, 1923, under the University of Louisville. When arrangements were being made to have classes in occupational therapy it was decided by the university welfare league, and the school of social work that the latter named would add a department of occupational therapy to their school. This was done, the first class opening September, 1923. By fine cooperation with the University of Louisville academic and medical departments, the Louisville Normal School, and the Louisville City Hospital, a strong course has been worked up. The year 1923-24 "occupational therapy" will be added to the title of the Louisville School of Social Work, as those interested feel that it may now be considered a permanent department.

Milwaukee Downer College

Length of course—Two college years. It is possible for a student in four years to obtain both her bachelor's degree and diploma in occupational therapy covering work of two year course.

Number of students—Five for diploma (two year course). Seven for college degree and diploma.

Philadelphia

Length of course—One year.

Number of students—Thirty-two, forty attendants.

All the members of the class of 1923, numbering twenty-eight (28), receiving their diplomas February 15, 1924, have been placed in paying positions with the exception of three, one of those being in Europe, and two doing volunteer service.

St. Louis

Length of course—Two years.

Number of students—Fourteen.

Increased amount of background work, so that the course instead of being mostly manual crafts with incidental lectures, should fall into three divisions: (1) general academic, such as English, psychology, sociology; (2) medical social service, namely, anatomy, physiology, kinesiology and massage, neurology, orthopedics, first aid; (3) manual crafts.



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(Signed) SISTER ROSE ALEXIS, Superintendent



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HOSPITAL EQUIPMENT AND OPERATION

With Special Reference to Laundry, Kitchen and Housekeeping Problems

Conducted by HERMAN SMITH, M.D., Superintendent
Michael Reese Hospital, Chicago, Ill.

PATHWAYS TO BETTER SERVICE THROUGH PROPER TRAINING OF EMPLOYEES*

BY MR. JOHN A. WYLLEY, FOREMAN, GENERAL SERVICE, UNIVERSITY OF CALIFORNIA HOSPITALS, SAN FRANCISCO, CAL.

THE past ten years have witnessed a progress in hospitals that cannot be excelled by any other important public activity. This progress is shown by the organization and development of such departments as social service, physiotherapy, occupational therapy and the like, and by the careful reorganization of existing departments, under the direction of a single hospital administrator. This evolution of the hospital has been reflected in the attitude of the public, which is rapidly awakening to a better understanding of the hospital's functions, its problems and its possibilities as an agent of public service.

The hospital occupies the most prominent place in the field of public health education, both from within and without its organization. Its activities in this direction are gradually reaching out to the extent that it has become the leader in community health.

This education begins within the hospital itself which, because of its peculiar activities, must train and develop its own organization to meet the demands made upon it. How readily this has been understood and acted upon, may be seen from the fact that hospitals generally throughout the country are in process of setting up machinery for the proper training and education of their employees in every branch of service.

The Hospital Labor Problem

Because of the rapidity with which the hospital has grown, from its small beginning to the immense establishments of today, it has been difficult to develop its lay labor in the number necessary to keep pace with its professional activities. For this reason, we find the labor problem the most difficult one with which the hospital

The many difficulties which the majority of hospitals experience in hiring and keeping satisfactory help has led to a study of the problem with a view to working out some means by which the hospital can develop the average floating employee into an efficient workman who will take an interest in the institution and will aim to fit himself for a better position in the hospital. As a student of the problem, Mr. Wylley, who has had several years of direct contact with the labor problem at the University of California hospitals, has undertaken to train the general service employees there through class work and personal guidance. His work strikes at the bottom of the problem and its success thus far warrants a trial of his plan in other hospitals where similar arrangements can be carried on under the general service department. Much of the success in training employees depends upon the supervision of a foreman who is able to teach employees.

administrator must grapple. The hospital cannot apply the same tactics to its personnel that can be applied to those in commercial fields as its problems are different in every respect, and, although the fundamental principles are identical, the problem of each particular institution may require a different angle of approach. Thus in order to develop an efficient organization of hospital employees, it is essential that an effort be made to train them along the lines desired, to produce the best possible results economically. Obviously a well-trained, intelligent and interested employee

can turn out more and better work in less time than a careless indifferent worker. This has been well demonstrated in the case of business houses which have found it necessary to train their own people to make it worth while for them to remain in the service, after their labor begins to earn dividends.

Under actual working conditions, a trained employee will do the work of one and two-thirds untrained employees. Moreover, he will do it in such a manner that his work will not interfere with other hospital work, nor become an annoyance to the patient, which is a point not to be overlooked, as it has considerable bearing on the traffic and noise problem of the hospital.

This article treats of the department which handles most of the unskilled labor, such as the maids, cleaners, elevator operators, pages and the like. In many institutions it is called the general service department. It includes most of what was formerly known as the housekeeping department and handles practically all other unskilled activities that were formerly under the supervision of various departments, but as the hospital became larger, conflicted in the scope of their activities. This department is under the supervision of a foreman who is responsible to the director, and who employs, discharges and arranges the activities of all employees of this class.

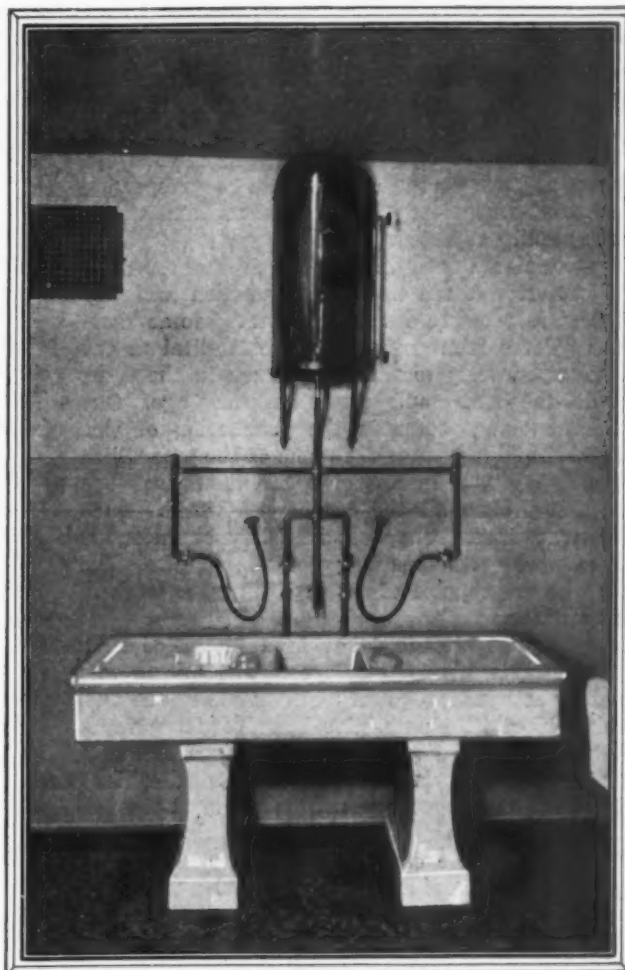
*This is the first of a series of articles on the general service department of the hospital prepared for THE MODERN HOSPITAL by Mr. Wylley.

*To avoid delays
is as good as to have
more beds*

In the great Ford Hospital, physicians have at their finger tips every modern facility for diagnosis and treatment. They are often enabled, therefore, by shortening periods of observation and treatment, to discharge patients sooner, making room for others.

With this important end in view, Ford Hospital officials devoted two years to planning alone. They studied the experience of hundreds of other institutions. They experimented with countless innovations in equipment.

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CRANE SOLID PORCELAIN HOSPITAL INFANT'S BATH, NO. C5800
IN USE IN THE FORD HOSPITAL

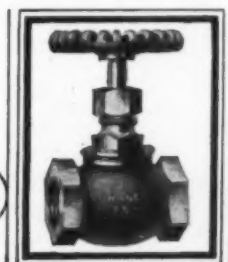
CRANE

GENERAL OFFICES: CRANE BUILDING, 836 S. MICHIGAN AVE., CHICAGO
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Crane Globe Valve No. I-B

This arrangement places the responsibility for the performance of certain necessary and important functions in a single individual, who has the authority and the means to work out the ordinary problems as they arise.

Recruiting and Training Employees

One of the principal difficulties of the hospital has been that the superintendent attempted to carry the burden of every detailed problem on his own shoulders. But these problems have become so complex that he has been forced to shift many of them to the shoulders of the respective department heads where they logically belong and where they can be speedily adjusted.

This is particularly true in respect to the unskilled labor problem. Heretofore this class has been made up largely of floaters who are commonly referred to as "hospital stiffies." These men drift from one hospital to the other and from one city to the other much in the same manner as did the hotel employees of ten years ago. One of the most important steps in the elimination of this type of labor will be to change the name of the jobs which they hold, such as porter and orderly, and then give them a title not associated with the commercial world. Such an arrangement should supply an additional incentive for which to work, and thus bring to the hospital field only people who are capable of accomplishing the work in the desired manner.

The name hospital attendant has been suggested as a suitable one for this type of employee. The person who undervaluates the "pulling power" of a name might well convince himself of its possibilities by advertising for a porter and then for an attendant, or for a maid and then a nurse's aid. In the former case the applicants will all be quantity with quality at a premium, while in the latter case, considerable good material can be selected from which to make a capable crew.

Having secured the best available material upon which to work, the next step in importance is to educate the individuals chosen up to the standard desired. This may be undertaken first by "driving home" the importance of the work upon which they are about to embark, its effect and relation to the patient, the hospital, and the community, what they can accomplish by application, the usefulness of his knowledge in every day life and what the present situation offers them in return for the effort they expend.

Promoting the Humanitarian Impulse

In training our employees we take advantage of the humanitarian character of the work in directing their efforts to sentiment, increase their usefulness, income and possibilities. How they accept and act on this principle is shown by the willingness with which they give up evenings to attend classes of instruction, by their application, which might bring them to work on days off, in order that they may finish something that is necessary to keep their section in proper condition.

The idea of training this class of labor has not been made with a view to reducing expense, but rather with the idea of delivering more and better service, educating the employee to the hospital concept of public health and placing him on a par with other classes of labor, insofar as working conditions, wages and treatment are concerned. The hospital cannot expect to obtain and keep employees with ideals, intelligence and determination, if these employees are to be paid at the rate of \$40 per month. The low wage paid is one reason why the labor turnover is much greater among this class.

It may be said that it is not desirable to have men of ideals in positions of this kind. In reply to this, the reader should be reminded that no person can be employed regularly in the care of the sick, unless he or she has the welfare of the patient at heart. The essential thing in good service in the hospital is that the employee constantly keep before him the fact that his service is contributing to the welfare of the patient. Some employees have little or no ideals, but if they can be brought out of the rut, it may be possible to obtain men who either have or who will readily acquire this essential characteristic.

Promotional Work and Better Service

In order to develop fully the proper *esprit de corps*, it becomes necessary to create a certain amount of rivalry, to acquaint the employee with the difficulties of other departments, and give some attention to the social side of the situation. This can best be accomplished by suggestion, guidance and reward.

In the first instance the men may be pitted against each other by a system of merits for work well done. The man who receives the greatest number of merits each two weeks, may be rewarded by an additional half day off, which reward may spur the force to greater effort. This system of merits is made to dovetail with the instruction given, so that when a reasonable score has been reached, the man passes up to the next higher grade, with a corresponding increase in pay, provided that he has been in the service for a stated length of time, and that he has shown himself capable of carrying a heavier load. This situation places the employee in a position where he will either make good or will leave the service. In either case the hospital will be the winner.

At first glance it would appear that this arrangement would cost the hospital more money. However, this is not the case, for as the employee becomes more efficient he is capable of more and better work. Where three men were previously used it may be possible to use two good men, and these men because of their increased value to the peculiar work of the hospital will not leave the service to enter a position where their labor has less value. The labor turnover is thus reduced to a minimum and the efficiency of the service is correspondingly increased.

The average lay employee of the hospital has not the slightest conception of the magnitude of the undertaking in which he is employed. In fact he feels that his particular task is the most difficult and arduous of any in the establishment. One of the best ways to bring about a better understanding among the lay employees is by the promotion of social and athletic events among themselves. This seems a bit far fetched but in actual practice it will result in the creation of a spirit of good feeling that cannot be brought about in any other way. The expense of these events are carried by the employees themselves. Many of these activities eventually result in the formation of social and athletic clubs. Commercial interests have long recognized the value of this feature of economic life and the manner in which they have acted upon it is evidenced by the time and expense given to its formation and guidance.

Trained employees are always better employees, training them can readily be accomplished without additional expense on the part of the hospital, but employees must be made interested and contented if the highest state of efficiency is to be developed, and a field is to be created from which to obtain sufficient material for future needs and to supply the demand for continuous service.

This is the Sani-Comfort —a better Bed Pan

The cushion is placed beneath the patient—the pan is then put into position. Cushion is covered with waterproof material. The pan is white enamel with a hood to protect the bed.



If *YOU* were sick in bed and you had your *choice* would you prefer to lie on **COLD HARD STEEL** or a comfortable, **FORM FITTING CUSHION**? Show this advertisement to a few of your patients and see what *they* have to say.

The idea is so simple, so obviously a solution to a trying problem that you will wonder how it is possible it was not thought of before . . . Order a dozen today, the price at retail is \$7.50, to hospitals \$6.00 each, \$72.00 the dozen, a little more than ordinary, but well worth the difference.

J. EDGAR THOMSON

253 Broadway

New York City

BELL SUSPENSION AND TRACTION TABLE

AFTER years of experience with all available suspension and traction tables, Dr. William Lisle Bell, Oakland, Cal., has devised what is known as the Bell suspension and traction table for fracture and orthopedic work. The table combines a number of features which make for greater convenience to the worker and comfort to the patient. Some of the outstanding features which are of interest to those who have had experience with other tables are: the foot piece which is provided with a heel pan; split spider pedestal, extension leg spars, movable adjustable uprights for supporting sub-splints from leg spars, elevating head and foot cranes, hammock support between head and foot cranes brought taut by a head and

along the center of the table between them. The table can thus be made to occupy as short a space and be as portable as a wheel stretcher, in less than a minute's time.

Figure 2 shows the table prepared for the reception of a patient. The cloth support, head and foot windlasses and foot pans are elevated. The four sub-tables may be seen locked about two inches below the taut canvas support.

Figure 3 shows the patient resting on the canvass steadied by the elevating cross tables. The bandaged foot is in the padded pan. The saddle is inserted through the splint in the canvas. The sub-splint is screwed down on top of the mast in place just above the left knee.

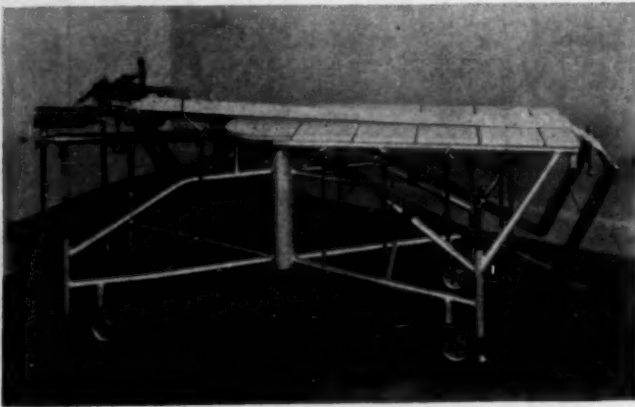


Figure 1.

foot split windlass crossing upper portions of head and foot cranes, four elevating cross tables under body hammock, saddle which enters pedestal through the split end of the drill or canvas support, and the few set screws and lock nuts which are readily understood by persons with experience in the use of other tables.

Figure 1 shows the table idle, with head and foot windlasses lowered and soft canvas support extending

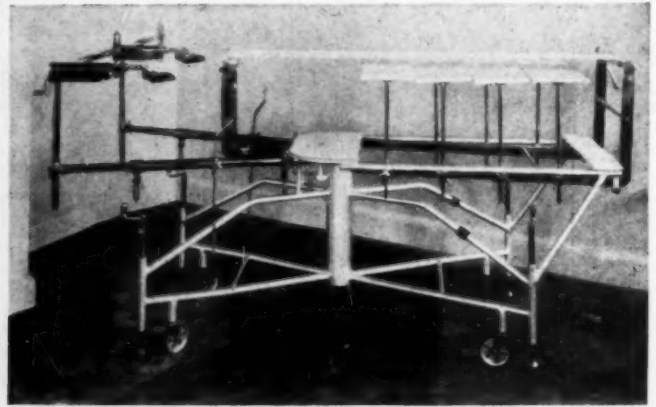


Figure 2.

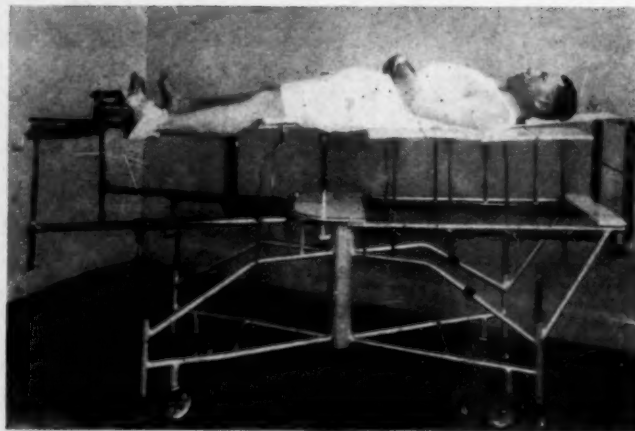


Figure 3.

Figure 4 shows the patient ready for full plaster case with sub-tables lowered and saddle and sub-splint still in place. As soon as the case is applied and partly set the sub-tables may be covered with a longitudinal pillow or two and elevated so as to support the patient.

Figure 5 shows the method of extending the spine. The saddle, sub-tables and sub-splints for leg support are down and the axillar lash is fastened

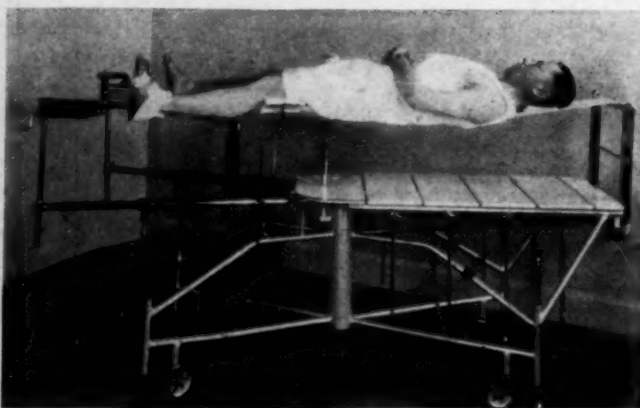


Figure 4.

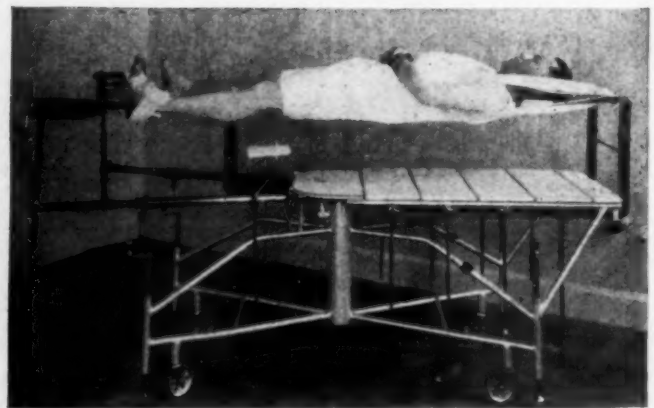


Figure 5.

FAITH


Faith in Religion—in American institutions—their ideals, spurs us on to greater achievements.

Faith in others—to recognize superior quality and workmanship—to appreciate the true value of *Good Glass Service* makes us strive to supply at all times *Glassware of Service*.



HAZEL-ATLAS TUMBLERS

have that smooth finished edge, clear color, sparkling polish and smooth bottoms.

OUR 
MONOGRAM
guarantees highest quality and lowest prices.

Sold only through merchants.

Ask your supply house for samples and prices.

HAZEL-ATLAS GLASS CO.

WHEELING, W. VA.

to the head windlass. The feet are fastened securely to the foot pieces so that the patient may be subjected to tremendous spinal pull. The foot pieces turn completely over so that the patient may be manipulated face downward while breathing through a slit in the head end of canvas.

The table may easily be rolled from room to room and to the bedside of the patient. When the case is thoroughly set the suspension sling should be cut at either end of the case, the saddle removed and the patient lifted to the bed.

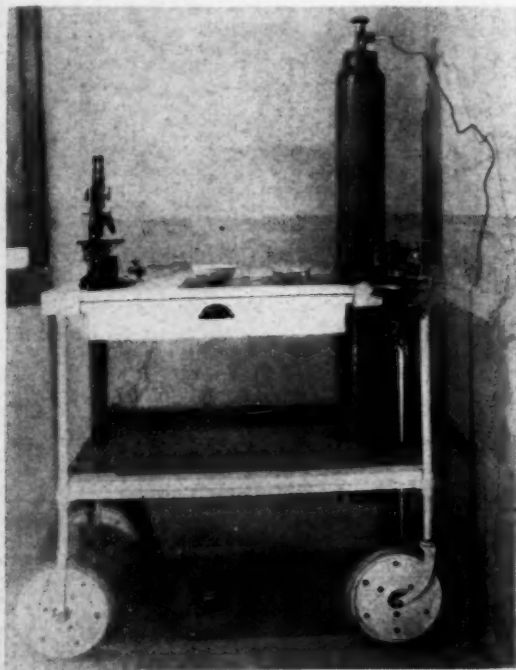
PRACTICAL LABORATORY EQUIPMENT

By WILLIAM McKEE GERMAN, M.D., Director of Laboratories, Blodgett Memorial Hospital, Grand Rapids, Mich.

With a little ingenuity and the cooperation of any clever carpenter or mechanic, many pieces of laboratory apparatus, which are extremely serviceable and of not unpleasant appearance, can be devised at minimum cost.

As the operating room is frequently distant from the equipment for frozen tissue diagnosis, we have constructed a simple portable unit which can be taken from the pathology department to the operating room, or a room adjoining the operating room, no matter how far distant the laboratory may be situated. I have seen many samples of the operating room being on the top floor and the pathology department in the basement, five or six stories distant, so that the time consumed in transportation of tissue for immediate diagnosis amounted to as much as three to five minutes, and another few minutes for a return report.

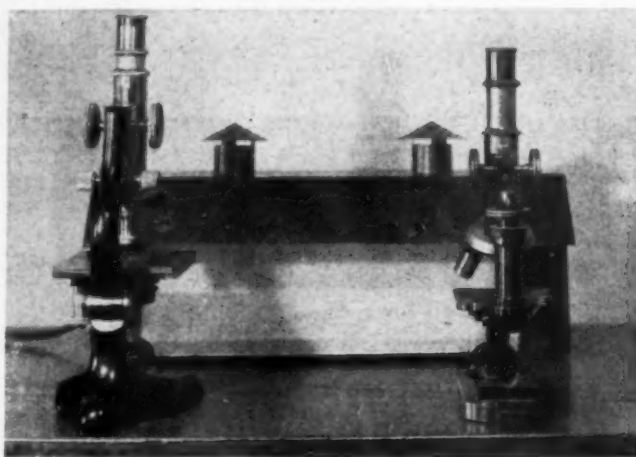
Realizing that if any value is to be derived from frozen tissue diagnosis the maximum time should be given the pathologist for diagnosis, with the minimum expenditure



Homemade lamp for microscopic and colorimetric work.

of time for transportation of specimens, we have found this unit, as shown in the accompanying photograph, of great value. It can be placed in the operating room if so desired, or, as is our custom, in the adjoining "scrub room" or preparation room.

This portable table carries a carbon dioxide tank, freezing microtome, microscope, substage microtome lamp



Portable table for transportation of frozen tissue.

which can utilize any wall plug, and a drawer for the necessary glassware, stains and solutions.

In this way diagnosis is done on the spot. The patient derives benefit from the small amount of time consumed; the pathologist derives the benefit of a more deliberate diagnosis, and the operator receives the benefit of a direct verbal report and opinion without delay, or distortion by transportation.

Such a unit is of simple construction. It is equipped with a large shelf, a spacious drawer for supplies, large, ball bearing wheel casters, rubber tired, and with a brake which holds its position securely.

We have found this type of rubber wheel useful in the construction of many pieces of portable apparatus. Our animal cages are equipped with such rollers in blocks of twelve cages, and can be moved in any place or at any time for purposes of cleaning or experimental work. Our feed bins are likewise of such portable construction, facilitating cleanliness and transportation of food and bedding to the animals.

A simple type of homemade microscope lamp can be made, at an extremely small cost, of galvanized steel painted a dull black. It can be of any length from two to five feet, and should be equipped with 75 Watt blue nitrogen globes which can be wired as a unit or with a separate switch for each. These globes are screened by white opal glass, and give an effect very closely resembling daylight. A small visor protects the microscopist's eyes from the glare. A simple radiating device on the top insures ventilation and cooling, one of these being used for each globe. It can be utilized for microscopic and colorimetric work equally well, and allows several microscopes to be used at the same time. The lamp shown in the accompanying illustration did not cost more than four dollars.

A CENTERING DEVICE FOR UPRIGHT EXPOSURES OF THE THORAX

By EDWARD S. BLAINE, M.D., Director, X-Ray Department, National Pathological Laboratories, Inc., Chicago, Ill.

In the technic of x-ray exposures of the thorax for pulmonary and cardiac conditions most physicians prefer the upright position of the film in which the long axis of the fourteen by seventeen inch film is parallel with the long axis of the patient's body. Thus, the narrow diameter of the film takes the width of the thorax. This fourteen inch spread of the film leaves very little margin in the average adult, and therefore it is highly important that the patient be accurately centered so that one or the other of the costal margins will not be lost. That this

To Nurses, FREE SAMPLE Clip and mail coupon below

The Nurse—

Missionary of

Better Personal Hygiene

Millions of women are grateful to the nursing profession for a new immaculacy, daintiness, peace of mind—under conditions once most distressing.



NURSES discovered the new, scientific way in personal hygiene. A way that assures exquisiteness, immaculacy, charm—freedom from embarrassment at all times. Peace of mind in all social and business activities.

This new way is called KOTEX. It was, as you know, discovered by nurses in wartime France, and perfected by science.

You of the nursing profession are missionaries—carrying the message of better health. It is natural that you should recommend KOTEX to all women.

Approximately 8 in every 10 women in the better walks of life today have adopted it. It has supplanted the old-fashioned "sanitary pads," and other make-shift, uncertain methods.

Tell your patients

Women value your professional knowledge—your practical experience—your intimate advice which leads to radiant health. The nurse who serves well, who counsels wisely, is gratefully welcomed. *She develops an appreciative, growing clientele.*

You know what a benefit KOTEX has become to all women. How it has brought daintiness, charm, peace of mind. How it saves women from wasting 1/6th of their time in a state of embarrassment, even fear. How it has given millions new poise, comfort, exquisiteness.

You are doing a valuable service when you tell your patients about KOTEX. It is practical help

of the greatest value. They will thank you later for your counsel. Your advice will mean better health, new immaculacy, to thousands of women.

Easy to dispose of

Nurses, tell your patients how easily KOTEX is discarded—just like a piece of tissue. No embarrassment, no difficulty—a point all women appreciate.

KOTEX is made from Cellucotton—the new super-absorbent. It *absorbs* 16 times its own weight; five times more absorbent than ordinary cotton. It absorbs moisture instantly, and holds it.

Ready-prepared, KOTEX comes in packages of 12 soft fluffy folds, sterile texture. Obtainable at all drug and dry goods stores.

As a health measure

It is but natural that you should sponsor the KOTEX idea—the new way in personal hygiene. As a public health measure, urge the installing of KOTEX Cabinets in all rest-rooms and other places where women congregate.

For nurses we have a new book, "Personal Hygiene for Women," written by a distinguished physician. If you have not used KOTEX, we offer, too, a test sample, sent in plain, unmarked wrapping. Simply fill in coupon now and mail.

Once a woman has used KOTEX, no other method will ever satisfy.

KOTEX



Mail this today

ELLEN J. BUCKLAND, G. N. M. H. 6-24
Care of Cellucotton Laboratories
166 West Jackson Boulevard, Chicago
I want to accept free trial offer with the understanding that it is absolutely confidential. Please send me in plain envelope—
☐ Book on Personal Hygiene ☐ Sample of Kotex

Name

Address

City

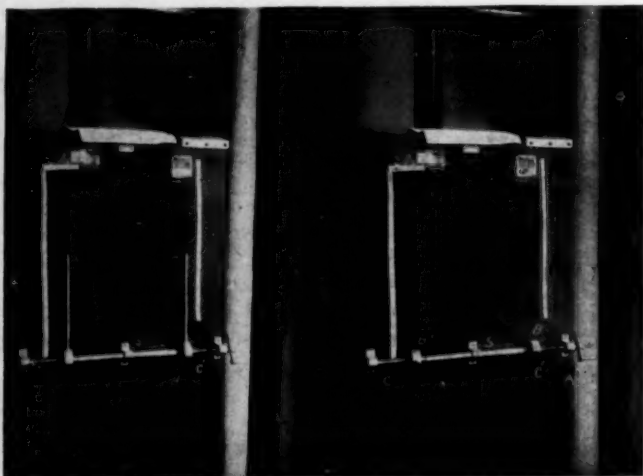
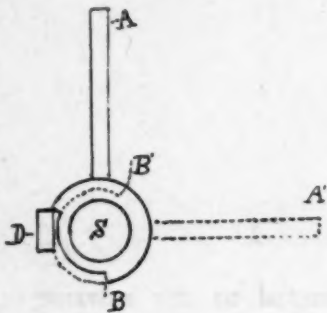
Hospital

often happens is attested by the technic of some operators who place the long diameter transverse to the patient so as to be sure that the entire width of the thorax will be projected on the film.

In order to provide the proper posing of the patient, a device was made and mounted on the face of an upright plate shifter, and by its use the average patient is easily, quickly and conveniently centered equidistant from the edges of the film, when placed vertically. This provides satisfactory results, especially in stereoscopy of the chest.

The device consists of a rod or shaft on which a right and a left hand screw thread are cut on each side of a center point; the center point corresponds to the center of the film. Three bearings hold this screw rod in place, and on the threaded portions are two arms which move equally to and from the center; this movement being obtained by turning a handle which is attached to the right hand end of the screw rod. These arms are placed horizontally when in use, and the patient stands between them facing the board. When not in use the arms are turned upwards out of the way, permitting freedom of movement around the apparatus.

A second rod of smaller diameter is placed behind the screw rod, the purpose of which is to hold the centering arms in horizontal position; a segment of the periphery of the arm support is cut away to permit a 90-degree movement from horizontal to vertical position.



In the illustrations, A and A' are the centering rods between which the patient stands, and on adjusting these close to the patient's sides he is forced to occupy the proper central point. B and B' are the arm supports. C is the right hand and left hand screw rod. D is the handle on right hand end of the screw rod for adjusting the position of the arms A and A'.

This device is mounted so as to be just below the lower margin of the lower edge of the film position.

It is seldom that one encounters an individual whose transverse diameter will not fall within the fourteen inch limit of the film, provided the focal spot of the tube be placed at least one meter from the film surface.

The upright plate shifter is also made use of in the exposures of the gastro-intestinal and urinary tracts in

upright posture, where this centering device is equally valuable.

CREPE PAPER BATH SLIPPERS

Today paper products are rapidly replacing china ware, glass ware and various articles of clothing, even boudoir slippers, it appears. One of the new paper products on the market is a crepe paper sandal to be worn when step-

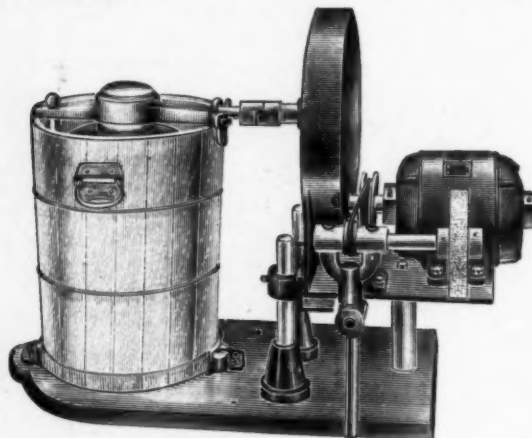


ping from the bath tub or shower bath. The sandals were designed to keep the feet dry and clean until the wearer is ready to use the towel. They not only keep the feet clean and dry but prevent the rubbing of dirt and dust on the towel. They are made in all sizes and sandals are inexpensive, for, of course, they can be used only once.

MOTOR-DRIVEN ICE CREAM FREEZER

An ice cream freezer operated by an electric motor can be used by hospitals of any size.

The equipment illustrated below can be secured in three, four, six, eight, ten, twelve, fifteen and twenty quart capacity. All freezers are furnished with an ice chipper having a thirty inch handle, suitable for shaving or crushing ice. A gear-driven ice crusher and a



belt driven grinding equipment for grinding cutlery, etc., are furnished at an additional cost.

The freezer tubs are finished in white with red base and guard. The motor is mounted on an iron base, and

Perfect Toast Service

24 Hours a Day!

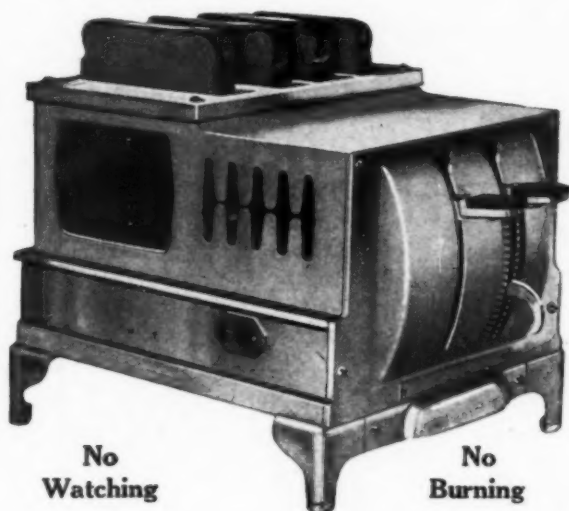
IT MAKES a big hit with your patients if their toast comes to them always **pip**ing hot, always crisp, tender and evenly browned, and never scraped, overdone or soggy. That's why we've received such enthusiastic reports everywhere from hospitals using

Strite Automatic Toaster

With the special 4-Slice Strite Automatic Toaster (shown here) installed in your diet kitchens, perfect toast service 24 hours a day is assured every patient. It enables any nurse to make sixteen orders of toast every ten minutes, **without attention!**

Toast Made Automatically

You simply place bread in the slots and depress two levers. That's all! This leaves the nurse free to attend her other duties. When the toast is done it pops up and the current automatically shuts off. The oven heat keeps toast **hot** until served. Adjustable timing makes possible perfect toast from fresh or dry bread.



No
Watching

No
Burning

Toast Has Rare Flavor

The Strite Toastmaster thoroughly dextrinizes the toast and gives it a delicious flavor that cannot be obtained any other way. It does not toughen the bread. Tests prove that Strite-made toast stays crisp even after cold, while toast made over a flame quickly toughens.

Cuts Toast-making Costs

Perfect toast from **every slice without watching, without burning**, means a big saving of time and bread. Current cost is low since current is on only while bread is actually toasting.

Put the 4-Slice Toastmaster in each of your diet kitchens. And for your main kitchen, use the famous 12-Slice Toastmaster with a capacity of 320 to 480 slices an hour.

Write nearest sales office or direct to us for complete details, including list of prominent hospital installations.

Waters-Genter Co.

34 N. 2nd St.

MINNEAPOLIS, MINN.

Chicago Sales Office: 123 W. Madison St.

Western Sales Office

C. N. HILDEBRAND

14 Montgomery St., Room 505, San Francisco

Eastern Sales Office

342 Madison Ave.

New York City

is adjustable to all the sizes of freezers. The gears are protected by a covering, and a guard protects the motor from ice, salt and water.

A SAFETY STEPLADDER

It is estimated that over 20,000 persons were killed or injured in falls from stepladders last year in industrial plants. Considering this fact, the hospitals should welcome a device which would help to reduce the hazard in work which requires the use of the ladder.

The safety ladder, illustrated below, has many features



that contribute to safety. It has a wide spread, preventing shaking and upsetting. This spread also makes it possible to place the ladder over low furniture and other equipment. A workman on any step of this ladder or on the platform can lift, push, or pull without danger of falling.

The platform is an unusual feature of this ladder. It provides a place for tools, bucket or material needed for the job. The side rails of the platform inspire confidence in the user of the ladder and enable him to work without the feeling of danger. The ladder is easy to fold and carry. It is used in a number of hospitals.

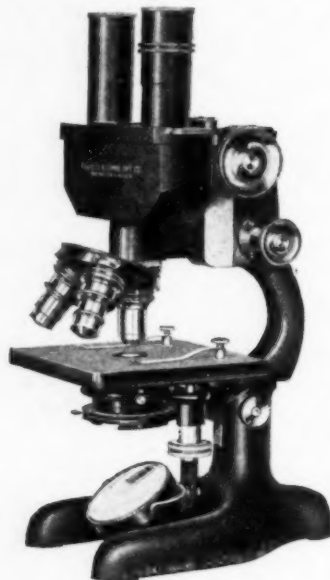
SIMPLIFIED BINOCULAR MICROSCOPE

Two eyes are better than one and especially is this true when using the eyes for close and accurate work.

The new simplified model binocular microscope, illustrated here, is of the parallel tube type and has all the adjustments usually found in a laboratory microscope.

The simultaneous use of both eyes offers advantages.

More detail can be seen with both eyes than with one alone, and the parallel eyepiece tubes allow relaxation of the ocular muscles so that eye strain is relieved. Adjustment can be made for the correct distance between the eyes of the observer and one tube has a spiral ad-



justment for the correction at differences between the eyes. This microscope fills a need for an instrument with which long continued service is possible with a minimum of strain.

SIMPLE ELECTRIC VAPORIZER

A simple electric vaporizer which may be attached to any electric light fixture and operated by anyone has been designed for the inhalation of medicated vapors in the treatment of head, throat and chest colds. The vaporizer consists of a sanitary paper cone which fits into



the perforated tray in the cylindrical wick holder. The paper cones may be disposed of after each using. Liquids, tablets or ointments may be used in the vaporizer.

Nurses Nowadays Do Not Need to Give So Much "Of Their Own Lives"

HOW familiar is the expression: "The nurse fairly worked herself sick trying to pull the case through." When, as a matter of fact, it was probably not the work, but the strain.

Often the nurse is made actually to suffer in her work because of uncomfortable, achy feet. Yet she must keep on and on, regardless of her own welfare.

How useless this sort of "sacrifice" has become. Thousands of nurses—in leading hospitals—have found a shoe that keeps their feet vigorous, youthful, comfortable—ready for any case. They are wearing the Arch Preserver Shoe, which has a concealed, built-in arch bridge that prevents strain, and an inner sole which is flat that prevents pinching of the nerves, bones and blood vessels. Happy feet—what a blessing to the sincere, hardworking nurse!

And well groomed feet, too—how much the right appearance, the smartest of style, adds to the happiness of the nurse herself. She finds her favorite models for all occasions in the Arch Preserver Shoe.

Let us send you our interesting little booklet No. 209, "Why the Arch Preserver Shoe Preserves the Foot," and "How to Keep the Feet Young."

The Selby Shoe Company

219 Seventh St.

Portsmouth, Ohio



"KEEPS THE FOOT WELL"

Sold by over 2000 dealers. Look for this Trade-Mark on the sole and lining. Styles for all occasions. All widths, AAAA to E. There are seven patents embodied in Arch Preserver Shoe construction. These are vested solely with The Selby Shoe Company, Portsmouth, Ohio, for the making of women's and misses' shoes, and with E. T. Wright & Company, Inc., Rockland, Massachusetts, for the making of men's and boys' shoes.



Nature plans that the foot rest on heel, ball and outside arch.



Civilization demands that heel and arch be raised.



The Arch Preserver Shoe satisfies both Nature and Civilization.

THE ARCH PRESERVER SHOE

Supports where Support is needed. — Bends where the foot bends

MEETINGS, CONVENTIONS AND CONFERENCES

INDIANA HOSPITAL ASSOCIATION HOLDS THIRD ANNUAL CONFERENCE

NURSING education, the training of hospital attendants, the hospital as a factor in community health and hospital social service were some of the outstanding subjects discussed at the third annual meeting of the Indiana Hospital Association held at the Hotel Anthony, Fort Wayne, April 23 and 24, 1924.

The convention opened with a dinner at the Hotel Anthony at which Dr. H. A. Duemling, chief surgeon, Lutheran Hospital, Fort Wayne, acted as toastmaster. There were three after-dinner speakers: Miss Mary Roberts, editor, *American Journal of Nursing*, who spoke on "Tendencies in Nursing Education"; Mr. John A. Lapp, National Catholic Welfare Council, Chicago, Ill., who spoke on "Hospital Liability"; and Mr. Charles M. Niezer, president, First National Bank, Fort Wayne, who spoke on "Reconstruction."

Miss Roberts called attention to the fact that schools of nursing are now attempting to prepare their students to function efficiently after they leave the hospital, instead of merely teaching them to be efficient under supervision in the hospital where they receive their training. More and more nursing schools have as their objective the preparation of nurses for community service, and because of this Miss Roberts contended that it was not fair to ask the hospital to assume the entire burden of educating the nurse; the burden should, in large part, be assumed by the community. Among noticeable modern tendencies in nursing education, Miss Roberts mentioned the following: better coordination of teaching and practice; better trained teachers; careful analysis of the nursing needs of the smaller communities; the financial support of nursing schools as schools rather than as integral parts of the hospital, and the grading of schools of nursing.

Mr. Lapp in speaking on "Hospital Liability" warned hospitals to protect themselves against inefficient physicians, surgeons and nurses, as well as against imposters who seek to hold hospitals liable for damages in every known way.

Speaking on the subject of "Reconstruction" Mr. Niezer emphasized the need of adequate hospital facilities in every community, for the rehabilitation not only of the physically ill but also of the mentally diseased.

Training Hospital Attendants

The opening paper on Friday morning was read by Mrs. Ethel P. Clarke, director, Indiana University Training School for Nurses, Indianapolis. Her subject was

"The Training of Hospital Attendants." "The practical nurse," said Mrs. Clarke, "is with us, and the important consideration is to see that she is properly educated and supervised." Mrs. Clarke called attention to the fact that New York, Missouri, California, Maryland, Michigan and Indiana already have laws covering trained attendants. Attendants should preferably be trained in hospitals which do not maintain nurses' training schools. They should be given a twelve months' course under a well-qualified graduate nurse. Mrs. Clarke called attention to the fact that investigations had shown that nurses spend from one-quarter to one-half of their time on cases that could be cared for effectively by less qualified individuals. Women who take courses as trained attendants should have a grammar school education. The age limit may be more flexible than in the case of nurses. However, it should be not less than eighteen years but may be as high as forty-five. They should be taught household economy and cookery, the ordinary things necessary in simple treatment of disease, the basic laws of personal hygiene, and enough bacteriology to protect themselves and their patients. They should also have a sound ethical training which will enable them to understand and observe their limitations.

Nursing Schools and Community Support

Following Mrs. Clarke, Miss Mary Roberts, editor, of the *American Journal of Nursing*, read a paper on "Community Responsibility for Nursing Schools." Miss Roberts contended that the care of the sick is a burden which should be carried by the entire community. To this end the community should be educated as to nursing requirements and, knowing these requirements, should see that they are provided for. "Superintendents," said Miss Roberts, "want interns but they do not maintain medical schools to educate them; they want dietitians but do not maintain schools of home economics. Why, then, should they maintain schools of nursing in order to secure nurses?" A school of nursing must, to be sure, be close to the hospital yet should have an individuality of its own. While a close ally of the hospital it should stand out as do the separate schools of a university. The community should not expect the hospital to carry the whole burden of the school, but should assist in maintaining it.

Commenting on Miss Roberts' paper Mrs. Clarke observed that in 1920 Indianapolis spent \$2,500,000 for cosmetics and only \$700,000 for the care of its sick, adding that what was needed was not knowledge as to how to

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spend money but how to spend it in the right direction.

Dr. C. C. Grandy of Fort Wayne read a paper on "Developments in Hospital Laboratory Service" in which he characterized the laboratory as a central point in which all diagnoses originated. Dr. Grandy maintained that all hospital patients were entitled to the ordinary laboratory examinations. He referred to two ways of meeting the expense of the laboratory, one being to charge each individual for the laboratory service rendered and the other to charge all patients a given sum, regardless of what examinations had been made. He favors the latter method. In the discussion of this paper it was brought out that some hospitals maintain their laboratories by charging each patient an entrance fee of \$2. Others charge one day's room rent. It was pointed out that this latter method could not well be used where patients stayed in the hospital but a day or two.

The closing paper of this session was on "Diabetic Diets" and was read by Miss Margaret Callahan, chief dietitian, St. Vincent's Hospital, Indianapolis.

Friday afternoon's session began with an address by Dr. M. T. MacEachern, president, American Hospital Association, Chicago, Ill., on "Limitations of the Hospital in the Care of Patients." Dr. MacEachern presented detailed statistics relative to the hospital facilities that should be provided by the community for various types of disease, and dwelt upon the complicated service now rendered by the hospital and the consequent mounting cost of its services. This increased cost is one of the serious limitations of the hospital and careful planning is needed to overcome it. This calls for an intelligent cost accounting system and careful investigation of the financial condition of various patients, as well as a determined effort to establish the responsibility for payment and the formulation of a definite scheme for obtaining payments from patients and, in some instances, from the consolidated revenue of the state.

The remainder of the afternoon was devoted to a round table discussion. Miss Talitha Gerlach, Indiana University, in speaking on the social service field work of the Robert W. Long Hospital, listed some of the motives that led to the establishment of the hospital's social service department as: Resourcelessness of sick people; economy for the hospital and the family (especially true in cardiac cases); greater efficiency in medical service; education; accumulation of medical social knowledge.

Medical Social Service Discussed

In a paper on "Real Values," Miss Edna G. Henry, social service department, Indiana University, Indianapolis, characterized the function of medical social service as the study of character under the adversity of sickness.

Following Miss Henry's paper, Miss Irma Collmer, executive secretary, St. Joseph's County Anti-Tuberculosis League, South Bend, spoke on "Medical Social Service for Tuberculosis Patients." She referred to the excellent advice frequently given by the physician which is not acted upon unless a social service worker sees that it is accepted and made effective by being acted upon at once. She also pointed out that it often takes a person from the outside to show the patient what he should do. Miss Collmer went on to say that financial assistance is often an important factor in the cure of tuberculosis cases and recommended the use of grants and loans so as not to pauperize the family. Social service is often helpful in counteracting well-meaning but unwise interference in treatment by relatives and friends. Miss Collmer maintained that for the majority of tuberculous patients the

sanatorium rather than the home is the proper place for treatment.

Guarding Against Delinquent Accounts

Dr. C. M. Combs, superintendent, Union Hospital, Terre Haute, discussed the question of "Patients' Delinquent Accounts." Hospital accounts, he pointed out, are often delinquent because the hospital fails to make definite arrangements when the patient enters and frequently lets him take too expensive accommodations. Hospitals should let patients know exactly what their services cost and in making financial arrangements should confer with the sanest member of the family. Insisting on the first payment in advance for one or two weeks, said Dr. Combs, brings the matter of the hospital charge sharply to the patient's attention. While advance payments should consistently be asked for, they cannot always be secured. In the latter case monthly statements should be sent for a period of three months after which the bills should be placed in the hands of a collecting agency. Dr. Combs found in his experience that losses came not from private patients but from part-pay patients, who came to the hospital expecting to stay two weeks and had to stay five or six. Dr. Combs urged the use of an admitting blank which permits patients to pay, and warned hospitals not to let the doctors vouch for the hospital bills of their patients. Time and trouble should be taken at the outset to arrange for the payment of bills, thus eliminating trouble later on. Hospitals, in Dr. Combs opinion, are not justified in asking the public to bear their burdens when these are due to bad business methods.

In discussing the question of "Centralization in the Dietary," Miss Margaret Rogers, superintendent, Lafayette Home Hospital, Lafayette, said that the desirability of a centralized system depends on the size and type of construction of the hospital building. She felt that there is a distinct advantage in the central diet kitchen plan, especially if the dietitian is given complete control of the food service.

Relation of Design to Operation Costs

Dr. M. F. Steele, superintendent, Methodist Hospital, Fort Wayne, discussed the subject of "Hospital Budgets and Costs." He pointed out that the design of the hospital building has a definite bearing on the cost of running the institution and urged physicians to bear in mind the interests of the hospital in requisitioning equipment and supplies.

The concluding speaker of the round table was Mr. R. B. Thieme, who spoke briefly on "Soft Water in the Hospital."

The convention went on record as indorsing National Hospital Day and urged all hospitals in Indiana to observe it.

The session concluded with the election of the following officers: president (re-elected), Robert E. Neff, superintendent, Robert W. Long Hospital, Indianapolis; first vice-president, Dr. M. S. Steele, superintendent, Methodist Hospital, Fort Wayne; second vice-president, Miss Margaret Rogers, superintendent, Lafayette Home Hospital, Lafayette; secretary, Miss Harriet Jones, superintendent, Bloomington Hospital, Bloomington; treasurer, Miss Laura Lowe, superintendent, Bartholomew County Hospital, Columbus; trustees, Miss Edith M. Willis, superintendent, Good Samaritan Hospital, Vincennes; Robert E. Neff, superintendent, Robert W. Long Hospital, Indianapolis; Miss Louise Hiatt, superintendent, Clinton County Hospital, Frankfort, and Miss Hill, State Board of Charities, Indianapolis.

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NORTH CAROLINA HOSPITAL ASSOCIATION HOLDS SEVENTH ANNUAL MEETING

THE North Carolina Hospital Association held its seventh annual meeting at the Sir Walter Hotel, Raleigh, April 14. A large and enthusiastic assembly of doctors, nurses and hospital executives from nearly every hospital in the state were present. Three sessions were held, morning, afternoon and evening. At the opening session Mr. E. B. Crow delivered the address of welcome, extending a very cordial invitation to all of the representatives of the hospitals of the state and visitors. Dr. J. F. Highsmith, Fayetteville, responded and concluded his remarks by a most earnest appeal for higher and better services in the hospitals of North Carolina.

Urged Enforcement of Narcotic Laws

One of the features of the morning session was the address of the president, Dr. L. A. Crowell, Lincolnton, who spoke on hospital management, but laid particular stress on the better enforcement of the laws governing the distribution of narcotics. Dr. Crowell said that the better enforcement of the narcotic laws should engage the earnest and immediate attention of the medical profession, as well as hospital executives. "Our profession is essentially humanitarian. We are in a position to know the disastrous results that must follow in the wake of this perilous growing evil, and I feel that it is a duty incumbent upon us to take the initiative in devising means by which this evil can be checked, or may I say, entirely stopped. We should stir ourselves in the path of simplification and strengthening of the laws of North Carolina governing this subject, and this done, it should be our duty to insist on and aid in the vigorous enforcement of these laws." A large part of his speech dealt with hospital operation and the training of nurses, especially in hospitals.

Dr. C. M. Strong read a paper on "Simplicity and Economy in the Operating Room." "The first place visitors are taken in a hospital is the operating room," said Dr. Strong, "where we dilate upon the latest and most costly operating table, which has fifty-seven varieties of movements, when we all know that only two or three are necessary. The doctor also spoke of the extravagant use of catgut, gauze, gloves, etc. He also spoke of the lack of economy in laundry. For the most simple operation two sheets and twelve towels are used when only four towels are needed."

How the Hospital Becomes Unpopular

Dr. Harold Glascock read a paper entitled, "A few Things that Bring Surgery and Hospitals in Disrepute with the Public." Wrong diagnoses account for many cases returning with the same complaint or transferring to other surgeons, who are not always considerate of the mistakes of others. These cases often go about the streets berating the surgeon and condemning the profession. Dr. Glascock said there was nothing in his opinion that operates against the popularity of a hospital as much as the militant superintendent, who rubs people the wrong way, is unsympathetic, unkind to visitors and who scolds nurses in the presence of visitors.

Dr. John Q. Myers, Charlotte, read a paper on "Why Some Hospitals are Unpopular?" One of the reasons is a lack of sufficient number of student nurses to care properly for all the patients in the hospital, and some outside

nurses employed by the hospital on floor or special duty sow the seeds of discord, and the student nurses become disloyal to their supervisors and less attentive to their patients. He also said that hospitals which are inefficiently maintained are usually ones which are unpopular, that hospitals also become unpopular when patients with typhoid fever, pneumonia, malaria and neurasthenia, are all placed in one ward or even on the same floor in separate rooms. Another important thing often overlooked is the personal attention which should be given to visitors and relatives of patients.

Dr. Annie L. Alexander read a paper on "How to Make a Hospital Popular." She emphasized that the hospital is primarily for the benefit of the patient. She said that the hospital, to be successful and popular with the public, must let the public know what it is doing. Confidence and good will must be created. The hospital is for the public service and should be put before the public mind just as the city and county health service is. The best way to popularize the hospital is through the patients. "Make every patient a booster instead of a knocker," she concluded.

Miss E. A. Kelley, superintendent Highsmith Hospital, Fayetteville, read a paper on "A Few Good Reasons for More Careful Teaching of Student Nurses." This paper was built around facts gained from two recent state board examinations, as Miss Kelley is a member of the state board.

Miss McDuffie read a paper on the "Duties of a Whole-time Instructor in a Small Hospital." The paper gave step by step how nurses were trained and instructed by their instructor, together with the best time schedule to be used for different training and instruction in the hospital.

Hospital Efficiency Defined

Dr. C. S. Woods, superintendent, St. Luke's Hospital, Cleveland, Ohio, and also president of the American Protestant Hospital Association, read a paper on "What is an Efficient Hospital?" "We speak of one hundred per cent efficiency as though we really knew what it was," Dr. Woods said. It doesn't really interest us whether our efficiency is one hundred per cent or some other per cent. We are obligated by every consideration of duty, however, to regard our task as a measurable one, a thing which may be weighed in the balance, an entity which can actually be set apart from other things.

The most efficient hospital in the opinion of Dr. Woods is that hospital which takes the most care of the selection of its medical and nursing personnels, which gives its student nurses the most complete theoretical and practical training and which keeps the best records. He emphasized the point that a hospital must know what it is doing in concrete terms just as much as any business must know what are its profits and losses, and their causes.

Dr. Henry Norris, Rutherfordton, read a paper on service. He brought out that we cannot run our institutions in a purely cold-blooded business manner, with the humanitarian side minimized, and give our best service in the broadest sense. It's no uncommon sight in many hospitals, large and small, to see poor people kept waiting when they could easily be disposed of in a comparatively

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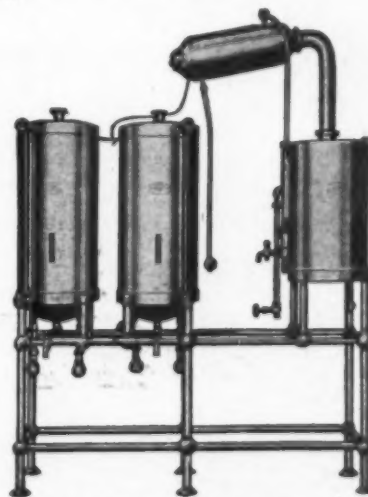
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short time by a little more effort on the part of the attending doctor or nurse.

The evening session was taken up by the Cleveland, Ohio, report of Mr. F. E. Chapman, director, Mt. Sinai Hospital, who spoke on "Hospital Development, Planning and Construction." Mr. Chapman defined the term hospital and then outlined the necessary steps which are required to establish a hospital. He urged a thorough survey of the needs of the community, and the purchase

of three times the amount of land originally needed so that the institution may easily be enlarged to meet the demands of a growing community. His paper was discussed by Dr. J. P. Monroe, Charlotte Sanatorium, Dr. J. T. Burroughs, High Point, and Mr. C. C. Hook.

The officers elected for the year are Dr. C. M. Strong, Charlotte, president; Dr. Robert Jones, New Bern, vice-president, and Dr. James R. Alexander, Charlotte, secretary and treasurer.

HOSPITAL SOCIAL WORKERS ANNOUNCE PROGRAM OF TORONTO MEETING, JUNE 25-JULY 2

ATENTATIVE program for the sessions of the annual meeting of the American Association of Hospital Social Workers to be held in Toronto, June 25 to July 2, has been arranged. Following is the outline of the program:

Wednesday, June 25—10:30-12 a. m.

Program meeting: "Social Ethics."

Speakers: Dr. Richard C. Cabot, professor of social ethics, Harvard University, Cambridge, Mass. (paper to be read). Miss Lucy Wright, assistant to Dr. Cabot, department of social ethics, Harvard University.

2 p. m.—3 p. m.

Round Table on "Technique of Social Treatment."

Leader: to be announced from psychiatric section.

3:15—5 p. m.

Business meeting with election of officers, etc.

Thursday, June 26 2:15—3:15 p. m.

Program meeting: "The Place of Convalescence in Public Health Organization." Speaker: Dr. Frederic Brush, superintendent, The Burke Foundation, White Plains, N. Y.

Business meeting of psychiatric section.

3:15—4:15 p. m.

"Book hour"—speaker to be announced.

4:15—5:15 p. m.

Round table: "Records"

Leader: Miss Mabel R. Wilson, director, social service department, Children's Hospital, Boston; chairman, committee on records, American Association of Hospital Social Workers.

Friday, June 27—2:15—3:45 p. m.

Program meeting: "Need of Psychiatric Social Work in a General Hospital."

Speakers to be announced by Psychiatric Section.

4—5:30 p. m.

Business meeting.

Presidential address—Miss M. Antoinette Cannon, New York, N. Y.

Report of districts of the association.

Saturday, June 28—Noon

Luncheon: "The Work of the Hospital Almoner."

Speaker: Miss A. E. Cummins, St. Thomas' Hospital, London, England.

Afternoon

Play.

Monday, June 30,—3 p. m.

Round table: "Training."

Leader: Miss M. Antoinette Cannon, president of association.

Tuesday, July 1—2:30—3:30 p. m.

Round table: "Recreation."

Leader: Claudia Wanamaker, Institute of Juvenile Research, Chicago, Ill.

2:30—3:30 p. m.

Round table: "Organization and Administration of Small Departments."

Leader: Mrs. Martha J. Megee, social service consultant, Pennsylvania Department of Welfare, Harrisburg, Pa.

3:30—4:30 p. m.

Round table: "Organization of Treatment in Rural Health Centres."

Leader: To be announced by psychiatric section.

4:30—5:30 p. m.

Program and round table: "Convalescence."

Leader: Miss Keefer, Department of Public Health, Toronto, Can.

Speaker to be announced.

4:30—5:30 p. m.

Round table on "Social Treatment of Cardiacs."

Leader: Miss Elsie Wulkop, social service department, Massachusetts General Hospital, Boston, Mass.

TRI-STATE ASSOCIATION TO MEET AT MADISON, WIS., JUNE 25-27

The Tri-state Hospital Association, comprising the states of Wisconsin, Minnesota and Iowa, will hold its annual meeting at Madison, Wisconsin, June 25, 26 and 27. The sessions will be held in the assembly hall of the state capitol. The adjoining parlors, committee rooms, and the rotunda, will be given over to the displays of exhibitors.

While the program has not been arranged in detail the following speakers have consented to present papers on these subjects: Miss Gale Fauerbach, of the staff of instructors of Milwaukee Central School of Nurses; "The Central School of Nursing." Miss Marian Rottman, superintendent of nurses, Mount Sinai Hospital, Milwaukee, will lead the discussion. Dr. Bert W. Caldwell, superintendent, University Hospital, Iowa City, Iowa; "Types of Hospital." Dr. J. Miloslavitsch, professor of pathology, Marquette University, Milwaukee; "The Purpose of the Laboratory." Mr. E. H. Elwell, professor of accounting, University of Wisconsin, Madison; "Hospital Accounting." Other subjects on which there may be papers are hospital architecture, workmen's compensation, nurses' homes, and the hospital library. Dr. Charles R. Bardeen, dean of the medical school of the University of Wisconsin, will be one of the speakers.

One afternoon will be given over to sight-seeing and to visiting interesting points in and about Madison, including the plant of Scanlan-Morris Company.

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CONNECTICUT HOSPITAL ASSOCIATION HOLDS SEMI-ANNUAL MEETING AT NEW BRITAIN

DISCUSSIONS on topics of vital interest to Connecticut hospitals and a paper on "Humanizing the Hospital" by Dr. S. S. Goldwater, director, Mount Sinai Hospital, New York, N. Y., comprised the program of the semi-annual meeting of the Connecticut Hospital Association held at the New Britain Hospital, New Britain, May 3.

Describes Hartford Hospital Campaign

Following the reports of the secretary and committees, Dr. Lewis A. Sexton, superintendent, Hartford Hospital, Hartford, commented upon the exhibit of campaign literature of his hospital drive on display. In making an appeal to the public for funds in large amounts, Dr. Sexton believes that the reputation for good service is paramount. He gave as the three essential elements to such an appeal as (1) the institution must be rendering a real service to the community; (2) the cause for which the funds are sought must be worthy; (3) implicit confidence must be engendered in the management of the institution so far as the investment of money and disbursing of funds are concerned. He said that in making its appeal for \$300,000 the Hartford Hospital had first to explain definitely what disposition had been made of the \$500,000 secured in a drive five years ago. This was done by means of letters to every person on the list and the letters written upon stationery bearing not only the names of the drive committee but those of the finance committee as well.

One of the most interesting features of the campaign literature is the form of contract which is being used to make it possible for corporations and stock companies to participate and yet be allowed to deduct their contributions from their income tax returns. The contract can be entered into by any board of managers and has been the means of the hospital's receiving many thousands of dollars which could not have been secured otherwise, according to Dr. Sexton.

Group Nursing—An Economic Measure

The first question of the round-table discussion was "What can the hospital do to lessen the cost of special nursing to the patient?" discussed by Miss Anna L. Bengston, Middlesex Hospital, Middletown, secretary of the association, who suggested group nursing as a way to lessen the cost of nursing expense. Under this method she said that one nurse may have charge of two or more patients so that the seven dollar a day cost will thus be divided between two or more patients.

The value of hospital statistics was discussed by Dr. John T. Bresnahan, superintendent, Bridgeport Hospital, Bridgeport, who expressed his disfavor of voluminous statistics and would eliminate them entirely from the annual report. He brought out that the statistics contained in the annual report can be secured in another way from the histories.

Dr. Sexton said that after much study, he had come to the conclusion that the chief value of an annual report was as an advertising medium and that, as such, are not of much service outside their respective communities. He said that Hartford Hospital issues a thousand annual reports which cost eighty-four cents each. He figures that if these are instrumental in securing one donation of \$1,000 the issue is paid for. In response to the sugges-

tion of Dr. Bresnahan, a vote was taken and approved that the association recommend to the American Hospital Association that a committee be appointed to make a study of annual reports and recommend at their next meeting a standard form of report for the benefit of all the hospitals represented in the association.

The subject of the monthly bulletin was discussed by Dr. T. Eben Reeks, New Britain General Hospital, New Britain. In order to interest the people of New Britain and the surrounding community his hospital issues a monthly bulletin giving a morbidity report, expenditures, receipts, training school report, x-ray report, laboratory report, and interesting facts about the hospital.

Favors Allowing Patients to Smoke

What should be done to regulate smoking among patients, was discussed by Dr. Bresnahan who said that his hospital permitted ward patients to smoke one hour after meals and that private patients were allowed to smoke any time except after eight o'clock in the evening. Dr. Willard C. Rappleye, superintendent, New Haven Hospital, New Haven, said that at his hospital smoking was not permitted in the wards, but that private patients were permitted to smoke in their rooms and convalescent patients, on the roof.

The round-table discussion was continued in the afternoon session. A questionnaire on the subject of furnishing the intern's uniforms, when the intern receives a monthly allowance, showed that New Britain General and Hartford hospitals supply uniforms. Five other hospitals supply uniforms while two do not.

A questionnaire on issuing diplomas to interns upon the completion of their service was unanimous in favor of that custom.

The replies to the question of how many hospitals in Connecticut have their own anesthetists showed that twelve hospitals have their own, most of whom are nurses. It was pointed out the Grace Hospital, New Haven, is in process of establishing a department of anesthesia which will be in charge of a full-time physician and an anesthetist with two nurses as assistants. Mr. Charles Lee, superintendent, Waterbury Hospital, Waterbury, said that his hospital has a member of the staff give the anesthetic. In the case of private patients he receives a remuneration.

Minimum Educational Requirement

The question of what should be the minimum educational requirement for admission to training schools, was discussed by Mr. Lee, who said that the one-year high school requirement should be the minimum educational requirement. In reply to the question of how much student nurses are paid, he said that during the first four months there is no allowance; the next fifteen months, they receive \$12 a month; the next twelve months, they receive \$15 and during the last six months, \$15 a month. It is understood that the nurses furnish their own uniforms, while text books are provided by the training school. In reply to the question of how many student nurses drop the course before graduation, Mr. Lee said that his hospital lost four out of twenty and another hospital lost five out of eighteen. In every instance, he pointed out, the students who dropped out were those who did not have one year of high school work.

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London

Following the discussion on nursing school problems, Dr. Reeks introduced Dr. S. S. Goldwater, who read a paper, "On Humanizing the Hospital," which appears in full on page 539 of this issue.

The meeting was concluded by a short talk concerning trends in hospital planning by Mr. Edward F. Stephens, of the firm of Stephens and Lee, Boston, Mass., who has

just returned from a visit to the Pacific coast. Mr. Stephens called attention to the one-story community hospitals which are being erected in California, also the economical plan which is being instituted in higher building by the placing of utility rooms so that the service to two patients will minimize the distance traveled by the nurse.

NATIONAL TUBERCULOSIS ASSOCIATION HOLDS TWENTIETH ANNUAL MEETING

TUBERCULOSIS from the standpoint of hospital and sanatorium treatment received consideration in the papers and discussions of the twentieth annual meeting of the National Tuberculosis Association, held at Atlanta, Georgia, May 6-10, 1924.

The American Sanatorium Association, which met in conjunction with the association May 6, gave thorough discussion to sanatorium and home treatment with the general consensus of opinion toward a wider use of the tuberculosis sanatorium both as a means for treatment and of training tuberculous patients. The food problem in institutions was also the subject of considerable discussion in this section of the meeting. Dr. Harry Lee Barnes of Wallum Lake, R. I., pointed out many methods which make for economy in the buying and preparation of food in tuberculosis institutions.

Institutional aspects of the problem were also discussed in the clinical section where consideration was given to heliotherapy as an aid in the treatment of tuberculosis. For the first time in this country (and, in fact, in the world) Dr. Horace LoGrasso and Dr. Frank Balderry of the J. N. Adam Memorial Sanatorium, Perrysburg, N. Y., presented conclusive proof, both verbal and illustrative, that heliotherapy can be made effective, if properly administered in pulmonary tuberculosis. The secret of their method seems to lie largely in the care taken in the gradual radiation of the patient. Heliotherapy for surgical tuberculosis in adults was also given high praise by Major E. J. Bruns, U. S. Army General Hospital, Denver, Col. Other papers stressed the value of heliotherapy in tuberculous laryngitis and various forms of surgical tuberculosis in adults and children.

Next to heliotherapy, the clinical section laid emphasis upon the value of surgical treatment of various kinds in tuberculosis. Reports from various parts of the country dealt with "artificial pneumothorax" under a great many different aspects. A paper on "The Diagnostic Value of Thoracoscopy," however, was held by Dr. J. J. Singer, St. Louis, Mo. The paper dealt with the use of definite chest surgery both by means of the thoracoscope, following the method of Jacobaeus, and also by definite rib re-section, that is, the opening up of the chest by surgery for exploration and treatment purposes.

In the sociological section the emphasis of the program was upon two special phases of public health work, first, programs in rural communities, and second, child-health education. Under the first of these headings papers were presented showing the organization of rural health work, both official and non-official in various parts of the South.

A most interesting group of papers dealing with pioneer efforts for health work among negroes created great interest. The child-health education sections of the program, however, were most enthusiastically praised. It was generally agreed that child-health education has not yet reached a point where health workers and school men

can agree. Differences of opinion with regard to pedagogy in health teaching and with regard to the content of the message to be conveyed have not yet brought about a uniform opinion with regard to this important subject. On the other hand, the influence of the modern health crusade and other methods of health teaching seems to be developing a growing desire for some system whereby the teaching of health habits can be made a uniform part of all school curricula.

Research, particularly medical research, received more than unusual emphasis at the meeting. In the address of the president and in other ways medical research as a basis to the development of progress of tuberculosis work was given particular emphasis.

About five hundred people registered for the meeting representing every section of the United States. Dr. Charles J. Hatfield, Philadelphia, Pa., was elected president to succeed Dr. Livingston Farrand, president, Cornell University, Ithaca, N. Y. The guest of honor during the meeting was Mr. Einar Holboell of Charlottenlund, Denmark, who in 1904 devised the first Christmas Seal used anywhere in the world. From this Christmas Seal the seal now used by the United States was adapted in 1907.

AMERICAN SANATORIUM ASSOCIATION MEETS

The annual meeting of the American Sanatorium Association was held at Atlanta, Georgia on May 6, 1924, the day preceding the annual meeting of the National Tuberculosis Association.

Various reports of committees were considered and the following scientific program discussed:

The Home Sanatorium Movement. General Discussion opened by Dr. H. A. Pattison of the National Tuberculosis Association.

Hookworm, Malaria, and Tuberculosis, by Dr. Harry H. Boswell.

Shortcomings of Sanatorium Treatment, by Dr. Alexius M. Forster.

Food Problems in Institutions for Tuberculosis, by Dr. Harry Lee Barnes.

The subject of home sanatorium treatment prompted a very vigorous discussion and the passage of resolutions reaffirming the position of the association, that the sanatorium was the proper place to treat tuberculosis and that anything in the way of home treatment should be of a follow-up character. It was thought that "sanatorium extension treatment" was a suitable term to describe this.

Dr. F. M. Pottenger, Monrovia, Cal., was elected president for the ensuing year; Dr. David Lyman, Wallingford, Conn., vice-president; and Dr. Walter L. Rathbun, Cassadaga, N. Y., secretary-treasurer.

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	Objective	Secured
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Post Graduate Hospital, New York City.....	2,000,000	1,600,000
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Union Protestant Infirmary, Baltimore, Md.....	750,000	810,000
Church Home and Infirmary, Baltimore, Md.....	600,000	450,000
Miami Valley Hospital, Dayton, Ohio.....	500,000	515,000
Methodist Hospital, Fort Worth, Texas.....	500,000	502,512
Stanford University Hospital, San Francisco.....	500,000	500,000
Presbyterian Hospital, Denver, Colo.....	500,000	500,000
Maryland General Hospital, Baltimore.....	450,000	483,000
Paterson General Hospital, Paterson, N. J.....	400,000	450,000
Memorial Hospital, Pawtucket, R. I.....	300,000	422,190
American Hospital of Paris, France.....	300,000	375,000
Eliza Jennings Home, Cleveland, Ohio.....	300,000	362,056
Children's Hospital, St. Louis, Mo.....	300,000	330,000
Mercy Hospital, Pittsfield, Mass.....	250,000	328,000
University of Maryland Hospital, Baltimore.....	250,000	250,000
St. Mary's Hospital, Rochester, N. Y.....	225,000	344,890
Southside Hospital, Bayshore, Long Island, N. Y.....	200,000	230,000
White Plains Hospital, White Plains, N. Y.....	200,000	200,000
St. Lawrence Hospital, Lansing, Mich.....	200,000	206,000
Maternity & Children's Hospital, Toledo, Ohio.....	150,000	158,500
Methodist Hospital, Sioux City, Iowa.....	125,000	153,500
Pottsville Hospital, Pottsville, Pa.....	100,000	120,000
Hayswood Hospital, Maysville, Ky.....	100,000	116,800
Saratoga Hospital, Saratoga Springs, N. Y.....	100,000	116,000
Cape Cod Hospital, Hyannis, Mass.....		110,000
Ogdensburg City Hospital and Orphanage, N. Y.....	75,000	123,369
United Helpers Home, Ogdensburg, N. Y.....	75,000	116,000
Dobbs Ferry Hospital, Dobbs Ferry, N. Y.....	75,000	116,000
Vineland Hospital, Vineland, N. J.....	75,000	76,000
Shenandoah Hospital, Shenandoah, Pa.....	70,000	100,000
St. Francis Hospital, Poughkeepsie, N. Y.....	75,000	100,000
St. Francis Hospital, Port Jervis, N. Y.....	75,000	80,000
Newcomb Hospital, Vineland, N. J.....	50,000	60,000

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TENTATIVE PROGRAM OF OHIO HOSPITAL ASSOCIATION MEETING

The Ohio Dietetic Association and the superintendents of all tuberculosis hospitals will meet with the Ohio Hospital Association at Cedar Point, June 10, 11, 12, 1924. Invitations have been extended to the Michigan Hospital Association, the Indiana Hospital Association, the hospitals of Kentucky and West Virginia to attend the meeting, according to the announcement of Miss Mary E. Yager, president.

The following tentative program has been planned for the three-day meeting of the association:

Tuesday, June 10

10 a. m.

Registration.

Meeting of the board of directors.

Meeting of committees.

Inspection of commercial exhibits.

2 p. m.

President's address, Miss Mary E. Yager, Toledo.

Report of Executive Secretary, Robert G. Paterson, Columbus.

3 p. m.

Round table on administration including the following subjects: vacations, sick leave, rules and regulations, x-ray. Led by the Rev. A. G. Lohman, Cincinnati.

8:30 p. m.

Get-together meeting.

Wednesday, June 11

9:30 a. m.

Round table on buildings and equipment, led by Mr. Frank E. Chapman, Cleveland.

11 a. m.

Tuberculosis hospitals in Ohio, led by Dr. H. A. Pattison, New York, N. Y.

11:30 a. m.

An address by Dr. E. L. Hooper, president, state association of hospital physicians, Athens.

2 p. m.

Round table on dietetics, led by Miss Nellie F. Parrish, Massillon.

3 p. m.

"Present-day Trend in Nursing Education," by Miss Caroline V. McKee, Columbus.

3:30 p. m.

Round table on housekeeping and laundry, led by Sister Rose Alexius, Cincinnati.

7 p. m.

Annual Dinner.

Speaker—Thurman ("Dusty") Miller, Wilmington.

Thursday, June 12

9:30 a. m.

"The Relation of Hospitals to the State Department of Health," by Dr. John E. Monger, Columbus.

"The Relation of Hospitals to the State Department of Welfare," by Mr. John E. Harper, Columbus.

"The Relation of Hospitals to the Industrial Commission," by Dr. T. R. Fletcher, Columbus.

2 p. m.

Business meeting.

Report of committees.

Constitution and rules: membership, Dr. Bachmeyer; auditing, Dr. Wood; nominating, Rev. Lohman.

Election of officers.

Unfinished business.

Adjournment.

Program of National Biennial Nursing Convention

(Continued from page 591)

- nursing service, Association for Improving the Condition of the Poor, New York, N. Y.
- 12:45-2:30 Luncheon round table—"Rural Nursing," Chairman, Ruth Houlton, R.N., superintendent of public health nursing, division of child hygiene, State Board of Health, Minneapolis, Minn.
- 12:55-2:20 Luncheon round table—"Responsibilities, Privileges and Rewards of Directors," (Closed session of boards of directors of public health nursing associations.) Chairman, Gertrude W. Peabody, president, Massachusetts Association of Directors of Public Health Nursing Organizations, Boston, Mass.
- 4:40-6:00 Round table—"Affiliations for Schools of Nursing With Public Health Nursing Associations," Chairman, Gertrude E. Hodgman, R.N.
- Round table—"Publicity," Chairman, Mrs. Eva Anderson Friedeman; Charles Stelzle, New York, N. Y.

AMERICAN NURSES' ASSOCIATION SESSIONS

- 11:15-12:45 Organization discussion.
- 4:40-6:00 Round table—"Getting Young Graduates Interested in Organization, Particularly With Respect to Building Up Schools of Nursing Endowments," Chairman, E. M. Lawler, R.N.
- Round table—"Milestones in the Progress of Social Hygiene."
- Meeting of the National Committee on Red Cross Nursing Service.

NATIONAL LEAGUE OF NURSING EDUCATION SESSIONS

- 11:15-12:45 Organization discussion—"A Study on Budgets for Schools of Nursing," Chairman, Elizabeth A. Greener, R.N.
- Round table—"Adjuncts of Teaching," Susie Watson, R.N., Chairman.

Thursday, June 19

- 9:00-12:45 Section meetings.
- NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING SESSIONS
- 9:00-11:30 School section—"School Health—Progress and Promise," Chairman, Alice Dalbey, R.N.
- 9:30-12:00 Industrial section—"Social Hygiene in Industry," Chairman, Mrs. Marion T. Brockway.
- 10:00-12:30 Child Welfare—"Routines in Child Care," Chairman, Abbie Gilbert, R.N. (The film "Well Born," will be shown.)
- 10:00-12:45 Tuberculosis, Chairman, Anna M. Drake.
- "Tuberculosis and Nursing Education," H. A. Pattison, M.D.
- "New Theories, Methods, Treatment in Tuberculosis Nursing," Chairman, Anna M. Drake, R.N., Miss Alice Stewart.

AMERICAN NURSES' ASSOCIATION SESSIONS

- Mental Hygiene section, Chairman, May Kennedy, R.N., Illinois State Training School of Psychiatric Nursing, Chicago, Ill.; private duty section, Chairman, Frances M. Ott, R.N.; legislation section, Chairman, Roberta M. West, R.N.

NATIONAL LEAGUE OF NURSING EDUCATION SESSIONS

- Instructors' section, Chairman, Nellie G. Brown, R.N.
- "Changing Demands in the Training of Teachers," Isabel M. Stewart, R.N., Teachers' College, Columbia University, New York, N. Y.
- 12:55-6:00 Boat ride for delegates and guests. Michigan nurses to be hostesses.

Friday, June 20

- 9:00-11:00 Joint session—N. O. P. H. N., presiding.
- "Meeting the Demands for Community Health Work," Dr. Haven Emerson, professor of public health administration, Columbia University; Ella Phipps Crandall, R.N., associate general executive, American Child Health Association; William J. Norton, secretary, Detroit Community Fund.
- 2:30-4:30 Joint session—National League of Nursing Education, presiding.
- "Some Outstanding Activities in the Nursing Field," "University Schools of Nursing," "Nursing in Other Lands."
- 8:00-10:00 Joint session—N. O. P. H. N., presiding.
- "The Public and the Nurse," Dr. George Vincent, president, Rockefeller Foundation, New York, N. Y.

NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING SESSIONS

- 11:15-12:45 Organization discussion—"What Are Voluntary Organizations Going to Do Toward Meeting the Demand With the Funds That Are Available?" Chairman, Mary S. Gardner, R.N.
- 12:45-2:30 Luncheon round table (closed session) "Discussion of the Content and Method of Instruction in Principles of Public Health Nursing," Chairman, Katherine Tucker, R.N.

AMERICAN NURSES' ASSOCIATION SESSIONS

- 11:15-12:45 Organization discussion.
- 4:40-6:00 Round table, mental hygiene section, Chairman, May Kennedy, R.N.
- Round table—"Home Hygiene and Care of the Sick," Chairman, Isabelle W. Baker, R.N.
- Round table—"Value of the Public Health Nurse to All Nurses," Chairman, Florence M. Patterson, R.N.
- Discussion by Ada M. Carr, R.N.

NATIONAL LEAGUE OF NURSING EDUCATION SESSIONS

- 11:15-12:45 Organization discussion.
- 4:40-6:00 Round table—"Pediatric Nursing," Chairman, Gladys Sellar, R.N.

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BOOK REVIEWS AND CURRENT HOSPITAL LITERATURE

THE TREATMENT OF DIABETES MELLITUS

By Elliott P. Joslin, M.D., Clinical Professor of Medicine, Harvard Medical School; Consulting Physician Boston City Hospital; Physician to New England Deaconess Hospital. Third Edition.¹

Though this is spoken of as the third edition of Dr. Joslin's book on the treatment of diabetes, it is practically a new book, very much enlarged as well as revised.

A most remarkable feature of the book is the completeness with which it has been brought up to date. References as recent as November, 1923, being included in it, though it was off the press by the first of this year.

The discovery and use of insulin is discussed in detail and at great length. Banting's and Best's work leading up to their final results, incidental information obtained before the solution of the problem, Murlin's findings, and many other facts relating to the history of this new factor in medical therapeutics is the subject of the first chapter. Following this, the use of insulin in the treatment of diabetes is discussed from practically every standpoint—types of patients treated with insulin; the advantages of this form of treatment; the danger of carelessness or ignorance in its use and the way in which the treatment of diabetes has been "revolutionized," as is so commonly said.

The author gives instruction as to his method of administering insulin, the dosage, standardization of the unit and directions for patients using it in the home. The effect of insulin on hypoglycemia, blood fat, ketone bodies and metabolism is told and illustrations given of patients treated. As a matter of fact, throughout the entire text many "cases" are described to illustrate the subject under discussion.

It is impossible in a short review to mention all of the good points contained in this volume. The reason for emphasizing insulin is obvious, but we must necessarily confine ourselves to outlining the rest of the book as the author has outlined it in sections.

The headings indicate the interesting material presented: insulin; theory, etiology, incidence and curability; physiology and pathology; the examination of the urine, blood and respiration in diabetes; the diet in health and in diabetes; treatment; the management of the diabetic in office and hospital; foods and their composition; height weight scales, equivalents and tables for computing metabolism.—L. C. G.

NATIONAL HEALTH SERIES

The National Health Council, New York, N. Y.²

The first twelve booklets of the National Health Series, the pocket edition of the National Health Council, New

York, N. Y., are now in distribution. The series contains twenty books on all phases of human health written by leading authorities in the United States. The booklets are attractively bound with flexible covers so that they are particularly adapted for carrying in the pocket. They provide authoritative information on health subjects in a simplified form devoid of the usual technical phraseology.—M. B.

THE HOSPITAL CORPS HANDBOOK

A revised edition of the "Handy Book," published by the Bureau of Medicine and Surgery under the authority of the Secretary of the Navy.³

The 1923 handbook may be well called the "handy book" or bible of the hospital corps of the navy, for it presents in condensed form many facts of first importance in treating emergency cases as well as protective measures to insure health and physical fitness of the hospital corps and those in naval service.

The book is divided into twelve sections; history of the hospital corps, anatomy and physiology; first aid and minor surgery; nursing; preventive medicine, hygiene and sanitation; chemistry; pharmacy; materia medica; toxicology; bacteriology, blood work and immunity; special activities and information and administration; and contains many diagrams and illustrations which guide the reader.

PERSONNEL MANAGEMENT

By Walter Dill Scott, president, Northwestern University; president, The Scott Company, consultants and engineers in industrial personnel; director of committee on classification of personnel in the army; and Robert C. Clothier, formerly employment manager, Curtis Publishing Company; member of committee on Classification of personnel in the U. S. Army; vice-president of The Scott Company.⁴

Principles and practices of personnel management are treated in a thorough manner in "Personnel Management," by Walter Dill Scott and Robert C. Clothier. More than 600 pages are devoted to a treatise of the whole subject, a large part of which covers the problems of individual adjustment work. By means of charts and other illustrations, the authors explain methods of conducting mental alertness tests, special ability and other tests and the compilation of labor turnover, promotional and other useful charts and tables.

1. Lea & Febiger, Philadelphia and New York, 1923.

2. Funk & Wagnalls Company, New York and London, 1923.

3. Government Printing Office, Washington, D. C.

4. A. W. Shaw Company, Chicago, Ill.



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NEWS OF THE HOSPITALS AND SANATORIUMS

The department of "News of the Hospitals and Sanatoriums" is prepared each month just prior to going to press, for the purpose of presenting the latest authentic news regarding hospital construction, changes in personnel, and other matters in which the hospital field is interested. So far as we can ascertain, the sources of our information, while not guaranteed, are reliable.

General

Meetings of the Month.—The following hospital and allied organizations have scheduled meetings for this month: American Association of Hospital Social Workers, Toronto, Ont., June 26-July 2; American Medical Association, Chicago, Ill., June 9-13; American Association of Industrial Physicians and Surgeons, Chicago, Ill., June 9-10; American Nurses' Association, Detroit, Mich., June 16-21; American Psychiatric Association, Atlantic City, N. J., June 3-6; Catholic Hospital Association, June 30-July 23; National League of Nursing Education, Detroit, Mich., June 16-21; National Organization for Public Health Nursing, Detroit, Mich., June 16-21; Canadian Association of Nursing Education, Montreal, Que., June 26; and the Canadian National Association of Trained Nurses, Hamilton, Ont., June 23-26.

Veterans' Hospital at Northampton Opened.—The U. S. Veterans Bureau Hospital No. 95, Northampton, Mass., was officially opened May 12. The hospital is in charge of Dr. A. H. Pierce assisted by a personnel of 250. The buildings are two and three stories high and are equipped with all modern appliances for the treatment of neuropsychiatric diseases. The hospital will accommodate 462 patients.

California

1924 Appropriation for State Hospitals.—An appropriation of \$1,000,000 has been made available for the state hospitals during 1924. New structures will be erected at all of the seven state institutions. The Sonoma State Home, Eldridge, will have two buildings erected at a cost of \$200,000; Mendocino State Hospital, Talmage, will have an addition to the main building to cost \$120,000 and a \$60,000 new building; Napa State Hospital, Imola, one building for 120 patients at a cost of \$200,000; Stockton State Hospital, Stockton, three buildings at a cost of \$300,000; Norwalk State Hospital, Norwalk, two new additions at an estimated cost of \$240,000; Southern California State Hospital, Patton, four buildings at \$320,000, and the Agnew State Hospital, a school building and auditorium and a wing for attendants.

District of Columbia

Leaves Garfield Hospital.—Mr. James R. Mays, former superintendent, Garfield Hospital, Washington, has been

appointed superintendent of the Union Hospital, Fall River, Mass.

Made Hospital Consultant to District of Columbia.—Dr. S. S. Goldwater, director, Mount Sinai Hospital, New York, N. Y., has been appointed hospital consultant to the government of the District of Columbia, and will assist Mr. Harris, government architect, with the plans for the new Gallinger Hospital.

Hospital Social Service School Planned.—A hospital social service school is to be established at the Georgetown Hospital, Washington, D. C., by the National Catholic Service School conducted by the National Council of Catholic Women. The department is intended for the training of students in hospital social service work. The school will be opened in September.

Illinois

St. Anthony's Hospital to Enlarge.—St. Anthony's Hospital, Effingham, has let contract for a new addition which is to include an operating room and sterilizing department.

Norwegian Lutheran Home to Be Enlarged.—The contract has been let for the seventy-five bed addition, power house and laundry for the Norwegian Lutheran Home and Hospital, Chicago.

Salvation Army Hospital Opens.—The Salvation Army formally opened its new maternity hospital and home, Chicago, April 14. The hospital was erected at a cost of \$280,000 and will accommodate seventy-five women and forty infants.

Indiana

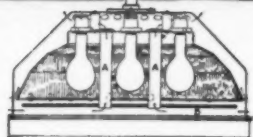
Morgan County Hospital Opened.—The new \$85,000 Morgan County Memorial Hospital, Martinsville, was formally opened to the public, April 13.

Kansas

City Takes over Contagious Hospital.—The old Bell Memorial Hospital, Rosedale, has been leased to the city for use as a contagious hospital. The municipal hospital is nearly completed. The staff will serve in both hospitals.

Maryland

State Hospital Appropriation.—The general assembly of 1924 has appropriated \$667,000 for the state hospitals for the insane and feeble-minded in Maryland. New structures will be erected at all state hospitals. At Springfield two wooden cottages will be replaced by a building to cost \$142,000 increasing the capacity of the hospital by fifty; at the Spring Grove Hospital, a wing to the A. D. Foster Clinic to accommodate 100 patients will be added at a cost of \$225,000, adding 100 beds to this hospital; at the Crownville Hospital, a home for the superintendent will be erected at a cost of \$25,000; provision for 100 additional



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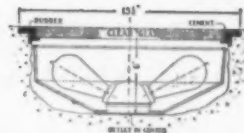
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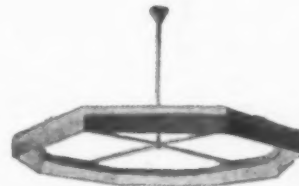
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Maryland General Hospital	And all State Institutions
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feeble-minded children will be made at the Rosewood State Training School by the erection of a dormitory at a cost of \$100,000.

Massachusetts

To Make Survey of Hospital.—The trustees of the House of Mercy Hospital, Pittsfield, have engaged Dr. S. S. Goldwater, consultant, to assist in a survey of the present hospital plant and in the formulation of a future building program.

Michigan

Work Started on St. Joseph's Hospital.—Construction work has been started on the new building for St. Joseph's Hospital, Mount Clemens, which will be erected at a cost of \$350,000.

Plan Sligh Memorial Hospital Buildings.—The Sligh Memorial Hospital for Children, Grand Rapids, has engaged Messrs. Williamson, Crow and Proctor of Grand Rapids as architects and Dr. S. S. Goldwater as consultant, for its new hospital buildings.

Minnesota

To Meet with Tri-State Association.—The Minnesota Hospital Association will meet with the Tri-State Hospital Association at Madison, Wis., June 25-27.

New Unit, Fairview Hospital Completed.—The new unit of the Fairview Hospital, Minneapolis, was completed and opened last month. The hospital now has a capacity of 225 beds.

Missouri

Trachoma Survey.—In collaboration with the Trachoma Hospital, Rolla, maintained by the public health service, a laboratory investigation has been inaugurated by the government. Headquarters will be maintained in the bacteriologic laboratory, department of hygiene of the Missouri School of Mines and Metallurgy, Columbia.

Dr. Kinsella to Be Chief of University Hospitals.—Dr. Ralph A. Kinsella has been appointed director of the department of internal medicine, St. Louis University school of medicine, and physician-in-chief at the university hospitals. Dr. Kinsella, who is now acting head of the department of medicine, Washington University, will assume his new duties, August 1.

Hospital for Crippled Children Opened.—The \$900,000 Shrine Hospital for Crippled Children, St. Louis, was opened to the public April 13. The hospital will take care of eighty children in addition to its out-patient service. Charity patients only will be received. Crippled children accepted must be under fourteen years of age and capable of being corrected to such an extent that they may be self-supporting in after life. The formal opening will be held this month. Dr. Leroy C. Abbot is surgeon-in-chief and Dr. Frederick A. Jostes, resident physician.

New Jersey

Jersey City to Have County Maternity Building.—A county maternity building is to be built at Jersey City in the near future.

St. Peter's to Have New Building.—A new building will be erected at St. Peter's General Hospital, New Brunswick, at a cost of \$300,000.

West Hudson Hospital Plans New Hospital.—The West Hudson Hospital, Kearney, is preparing plans for a new 100-bed hospital, construction of the first unit of which, to contain sixty beds, will be started this spring. Messrs. Scrimshaw and James Salmond Jr., are the architects and Mr. Charles F. Neergaard, the consultant.

Plan Site at East Orange.—The Homeopathic Hospital



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BOSTON, MASS.

of Essex County, now located in Newark, has purchased a two and one-half acre plot in East Orange and has had plans drawn by Crow, Lewis and Wick, Boston, Mass., for the first unit of 120 beds. Mr. Charles F. Neergaard is acting as consultant. It is expected that the construction will be begun this fall.

New York

Leonard Hospital to Enlarge.—A \$25,000 addition is to be erected for the Leonard Hospital, Troy.

St. Mary's Hospital to Have Addition.—St. Mary's Hospital, Amsterdam, has let the contract for a new addition.

Dr. Ebberts to Leave Buffalo State Hospital.—Dr. Harry E. Ebberts has resigned as manager of the Buffalo State Hospital, Buffalo.

Dr. Titus to Reconstruction Hospital.—Dr. Edward C. Titus has been appointed consultant in physiotherapy to the Reconstruction Hospital, New York.

Plan New Buildings.—Mr. Oliver H. Bartine is now engaged in making a study of the St. John's Hospital, Yonkers, New York, with a view to presenting a building program.

Hospital Bed Endowed.—The Progress Club, in commemoration of its sixtieth anniversary, has endowed a bed in the Hospital for Joint Diseases and one in Montefiore Hospital, New York, N. Y.

Clinic for Nervous and Mental Diseases.—The New York Hospital has added to its out-patient clinic a department for nervous and mental diseases. The clinic will be open on Tuesday and Thursday afternoons.

Dr. Roe to Hudson River State Hospital.—Dr. Charles E. Roe, senior physician of the Binghamton State Hospital, Binghamton, has been appointed clinical director of the Hudson River State Hospital, New York.

Contagious Disease Hospital Wanted.—A movement is on foot in Poughkeepsie to secure a city hospital for the treatment of contagious diseases. At present there is no place in the city for the isolation and care of such cases.

Open New Pavilion.—The New Rochelle Hospital, New Rochelle, opened its new private patients' pavilion the first week in May. The architects upon this building were Messrs. Crow Lewis & Wick, and the hospital consultant, Mr. Oliver H. Bartine.

To Raise Endowment Fund.—A fund of \$10,000 is being raised to endow a bed at the Manhattan Eye, Ear, Nose and Throat Hospital and Medical School in memory of the late Dr. T. Passmore Berens, who was professor of otology in the institution.

The Staten Island Hospital, New York, to Enlarge.—Mr. Oliver H. Bartine, Hospital consultant and superintendent of the Hospital for Joint Diseases, New York, has just completed a study of the hospital and presented a building program which has been approved by the building committee and the board of managers.

Masons Take Over Broad Street Hospital.—After months of negotiations, the Masons of New York City have reached an agreement with the Society of the Broad Street Hospital whereby the Masonic organization will assume the maintenance and support of the hospital. James Barber, founder of the hospital, will continue to be its president. The other officers elected were: Dr. William H. Dieffenbach, vice-president; Troy Alexander, head of the Masonic Hospital Foundation, treasurer; and Dr. Maximilian Stern, secretary.

Industrial Hygiene Clinic for Reconstruction Hospital.—Under the joint auspices of the Reconstruction Hospital, New York, and the industrial hygiene division of the state department of labor and the College of Physicians and

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Surgeons, an industrial hygiene clinic has been established in the Reconstruction Hospital. The clinic will provide opportunity for the diagnosis and treatment of occupational diseases that affect workers in many industries. Treatment will be given daily from 9 to 5 o'clock, with the exception of Saturday when the clinic will close at noon.

Reorganize Administration of South Side Hospital.—The South Side Hospital, Bay Shore, L. I., has reorganized its methods of internal administration, as the former methods were found to be defective on account of the overlapping spheres of the medical staff and the board of managers. This action was taken following the resignation of the staff to have taken place March 18. A meeting of the board of managers was held March 14 at which time a plan of reorganization was adopted to which the medical staff pledged their support and their loyalty to the hospital.

Lay Cornerstone of Hudson Towers.—The cornerstone of Hudson Towers Hospital Hotel, Seventy-second Street and West End Ave., New York, was laid on April 27. A unique feature of the exercises was the placing of a complete record of modern medicine in the cornerstone block in the form of a reel of motion picture film showing doctors performing important operations, together with glass stained specimens of all known disease-producing bacteria, and a collection of drugs regarded as specific cures for diseases, and a record of those diseases now regarded as incurable.

The hospital is to be twenty-two stories high with 400 rooms for patients and guests. It is expected that it will be ready for occupancy sometime this year. An entire floor will be reserved for examination rooms available to any physician or surgeon in the city. Some of the rooms are ensuite so that relatives of sick persons may live near them while they are being treated. Two floors have been set aside for visiting physicians and for a doctors' club.

North Carolina

Dr. Whittington Appointed Superintendent.—Dr. James B. Whittington has been appointed superintendent of the City Memorial Hospital, Winston-Salem, to become effective June 1. He will fill the vacancy made by the resignation of Dr. Thomas C. Redfern.

Ohio

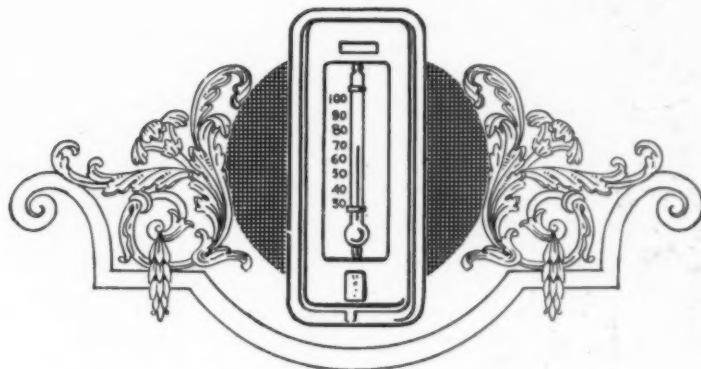
Hospital Association to Meet at Cedar Point.—The Ohio State Hospital Association will meet at Cedar Point, June 10, 11, 12.

Becomes Bluffton Community Hospital.—The name of the Mennonite Deaconess Home and Hospital, Bluffton, will be changed to the Bluffton Community Hospital.

To Select Site for Lima City Hospital.—The Allen County Medical Society recently appeared before the hospital commission and presented a petition asking for the location of a site for the building of the Lima City Hospital, voted at the November election.

Dr. Rogers to Orchard Springs Sanitarium.—Dr. Charles B. Rogers, who for the past thirteen years has been medical director of the Cincinnati Sanitarium, has assumed charge of Orchard Springs Sanitarium, Dayton, in a similar capacity. He will succeed Dr. Frank R. Lord, who resigned in April, after five years' service.

Mansfield Hospital to Have Social Service Worker.—The Mansfield General Hospital, Mansfield, has decided to employ a social service worker for field operations. In cases where a patient is discharged from the institution and is unable to provide for himself for some time, it will be the duty of the field worker to visit the home and arrange for assistance.



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Nine Hospitals to Give Medical Aid to School Children.—Nine Cleveland hospitals will give medical aid to school children in case of injury in or about schools, according to Dr. L. W. Childs, supervisor of health education of the public schools. This will be done because an outside physician cannot be called, as the school board cannot legally pay for a doctor's services, if the child's parents are unable to pay. The plan is that when the child has been treated in the hospital it will be turned over to the family physician.

Pennsylvania

Columbia Hospital to Enlarge.—The contract has been let for the erection of a new \$55,000 addition to Columbia Hospital, Wilkesburg.

Drive for Charleroi-Monessen Hospital.—A drive will be conducted to raise \$150,000 to erect a new building for the Charleroi-Monessen Hospital, Lock.

Northeastern Hospital to be Ready in October.—The new Northeastern Hospital, Allegheny Avenue, Philadelphia, will be ready for occupancy in October.

Annex for Samaritan Hospital.—Ground was broken, April 21, for the annex of the Samaritan Hospital, Philadelphia, which will be erected at a cost of \$400,000.

New Nurses' Home for St. Vincent's Hospital.—The contract has been let for the erection of a nurses' home for St. Vincent's Hospital, Erie, at a cost of \$100,000.

Dr. Wright Awarded Grecian Cross.—Dr. Valentine W. M. Wright, formerly resident physician at the Philadelphia General Hospital, has been awarded the cross of the chevalier of the Order of George I by King George of Greece for his work among the Greek refugees in Turkey.

Superintendent Hilker Resigns.—Mr. F. C. Hilker, superintendent, Hahnemann Hospital, Philadelphia, has resigned his position to become superintendent of the Lancaster General Hospital, Lancaster. Mr. Hilker will be succeeded at Hahnemann Hospital by Mr. S. J. Barnes, former superintendent, Pennsylvania Hospital, Philadelphia.

South Dakota

Bartron Hospital Makes Progress.—The annual report of the Bartron Hospital, Mitchell, has gained the attention of the press of that district because of the progress of the hospital which is recounted in the report. The hospital has made extensive physical improvements during the past year and has been placed on the approved list of hospitals which have met the minimum standard requirements set by the American College of Surgeons. Dr. Hans Goldbach, a specialist in internal medicine and skin disease, Vienna, Austria, has become a member of the staff during the past year.

Texas

New Building for All Saints Hospital.—A new building will be erected at All Saints Hospital, Fort Worth, at a cost of \$150,000.

Virginia

Winchester Memorial Hospital to Erect New Building.—Winchester Memorial Hospital, Winchester, will erect a \$200,000 building to replace the structure recently destroyed by fire.

Dr. Hall on Board of Central State Hospital.—Dr. James K. Hall, Richmond, has been appointed by the governor to be a member of the special board of directors of the Central State Hospital, Petersburg.

Charter Issued to Northampton-Accomac Memorial Hospital.—A charter has been issued to the Northampton-Accomac Memorial Hospital now under construction at

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Washington

New Hospital for Longview.—A new general hospital will be erected at Longview, in the near future, by the Longview Hospital Association.

Reconstruction Work Finished.—The reconstruction work on the Northern Pacific Hospital, Tacoma, has been completed at a cost of \$120,000.

St. Peter's Hospital Nears Completion.—The new St. Peter's Hospital, Olympia, is nearly completed and will be ready for occupancy sometime this summer, it is announced. It is a five-story reinforced concrete building which will accommodate about 300 patients.

Plan Norwegian Memorial Hospital.—The Norwegian Hospital, Seattle, which has existed under this name for the past year while operating in the old North End Hospital, is planning the erection of a new building on the hospital property, the first unit of which will be built sometime during the coming year. The hospital will be known as the Norwegian Memorial Hospital.

Open Government Hospital at American Lake.—The new government hospital erected on the north shore of American Lake has been opened. Fifty mental and nervous patients for the last few years housed in the U. S. Veterans' ward at the Western State Hospital, Steilacoom, have been removed to the new institution of which Dr. Leon M. Wilbor is medical officer in charge. The hospital has twenty-eight buildings and a capacity of 300 patients.

Wisconsin

Work Started on St. Mary's Hospital, Watertown.—Construction work has been started on an addition for St. Mary's Hospital, Watertown.

Dodgeville Lutheran Hospital to Have New Addition.—A \$55,000 addition will be erected to the Dodgeville Hospital, Dodgeville, in the near future.

Wausau Memorial Hospital Has New Addition.—The new sixty-bed addition to the Wausau Memorial Hospital, Wausau, will be ready for occupancy, May 1.

Plan New Hospital for Kenosha.—The first unit is being planned for the \$1,000,000 hospital which will be erected for St. Catherine's Hospital, Kenosha.

Wisconsin Association to Meet at Madison.—The Wisconsin Hospital Association will meet in conjunction with the Tri-state Hospital Association at Madison, June 25-27.

Dr. Green Succeeds Dr. Drake.—Dr. Morton K. Green, assistant at the state hospital for the insane, Mendota, has been named superintendent of the institution to succeed Dr. Frank I. Drake who resigned.

Wyoming

Dr. Frost in Charge of New Lincoln Street Hospital.—Dr. Isaac N. Frost is now in charge of the newly opened Lincoln Street Hospital at Casper.

Canada

Columbia Coast Mission to Erect Hospital.—A \$30,000 hospital will be erected at Alert Bay, B. C., by the Columbia Coast Mission. It will contain thirty-eight beds.

Halifax County to Have New Asylum.—An asylum for the chronic mentally ill of Halifax County, Windsor Junction, Nova Scotia, will be erected in the near future at a cost of about \$200,000.

Two New Wings for St. Joseph's Hospital.—Construction has begun on the two new wings to St. Joseph's Hospital, Guelph, Ont., at an estimated cost of \$140,000. The additional accommodations will provide for fifty extra beds, quarters for the nursing staff and two new operating rooms.

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Trade News and Publications

Organize as Groff-Bent Corporation.—The manufacturing establishments of Mr. Franklin L. Groff and Mr. George W. Bent, pioneers in the metal bedding industry, have been consolidated with headquarters and show rooms on the eighth floor, 218-232 West 46th street, New York, N. Y. The organization will be known as the Groff-Bent Corporation and will be composed of the three branches of the Bent Company, together with the Mersereau Metal Bed Co., Jersey City, N. J.; the J. R. Bunting Bedding Company, Philadelphia, Pa.; Gausau-Thompson, Brooklyn, N. Y.; Foster Bros. Mfg. Co., Baltimore, Md., and the Continental Bedding Co., Boston, Mass.

For Every Housecleaning Task.—The Pneuvac Company, Worcester, Mass., has issued a pamphlet, "For Every Housecleaning Task," illustrating the use of their electric Sweeper Vac with the motor-driven brush.

Catalogue of Bath Room Fixtures.—The Bay Ridge Specialty Company, Inc., Trenton, N. J., has issued a catalogue of its all-white bath room fixtures.

Distinctive Floors.—A folder describing the gold-seal treadlite tile of the Bonded Floors Company, Inc., a division of the Congoleum Company, New York, N. Y., has recently been received. The folder illustrates the varieties of design and contains pictures of rooms in establishments where these are in use.

Scientific Washing: Gray Work.—Bulletin Number 4, one of the series on scientific washing published by the Cowles Detergent Company, Lockport, N. Y., deals with gray work, its cause and cure. The bulletin contains a paper discussing gray work and how to prevent it by using scientific methods of washing.

Marsh Interceptors.—A new booklet published by S. L. Marsh, 1614 South Flower St., Los Angeles, Cal., shows the value of their sanitary grease interceptor for use in water pipes.

Solar Self-closing Receptacles.—This new 1924 catalogue of the Solar-Sturges Mfg. Co., Chicago, Ill., illustrates the use of the Solar self-closing receptacle for use in all departments of the hospital.

Encouraging Hospital Contribution.—A 16-page catalogue issued by James H. Matthews & Co., Pittsburgh, Pa., illustrates its line of bronze memorial and name tablets for installation in hospitals and allied institutions.

Paper Specialties for Hospitals.—The Kalamazoo Vegetable Parchment Company, Kalamazoo, Mich., has just issued a booklet illustrating its paper products such as K V P surgical waxed paper, obstetrical sheets, paper bandages, ice blankets, crib sheets and housekeeping paper products for hospitals.

Translucent Shades.—An illustrated leaflet describing its window shades, has been received from the Shurlox Awning & Shade Co., 561 W. Monroe street, Chicago, Ill. The shade material can be washed. Hartshorn or Columbia Spring Rollers and Silver Lake braided cotton cord is included in the completed shade. The leaflet also describes the line of Improved Shurlox awnings.

